University of Alberta

Having Twins:

The Experience of Mothers

by

Jeanne Elizabeth Van der Zalm

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Faculty of Nursing

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When I have been truly searching for my treasure, every day has been luminous, because I've known that every hour was a part of the dream that I would find it. When I have been truly searching for my treasure, I've discovered things along the way that I never would have seen had I not had the courage to try things that seemed impossible for a shepherd to achieve.

Paulo Coelho

The Alchemist

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *Having Twins: The Experience of Mothers* submitted by Jeanne Elizabeth Van der Zalm in partial fulfillment of the requirements for the degree of Doctor of Philosopy.

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FOR MY FAMILY

Abstract

The incidence of twin pregnancy has increased steadily since the early 1980s. This has been attributed to advancing reproductive technologies and an increasing maternal age at the time of pregnancy. However, little is known about womens' experiences of twin pregnancy and the meaning women attribute to their twin pregnancy experiences. In this research, the results of a hermeneutic-phenomenological inquiry into the twin pregnancy experience is presented. Interactive interviews were conducted with women who currently were pregnancy with twins or who had given birth to twins in the past. A variety of experiences were included: Women who experienced an uncomplicated twin pregnancy and those with pregnancy experiences of vanishing twins, extreme prematurity of twins, death of one or both twins before, at, or after birth, repeated history of twins, and twins with congenital birth defects. Interpretive analyses revealed that the meaning women attribute to their twin pregnancy is aligned with the socio-historical significance of the word 'twin'. Twins exist in our history and present culture as myths and legend, as a comedy of errors, as monsters, as doubles, as connected, as scientific controls, as copies, as clones, and in uni-form. It is the nuances of meaning associated with the 'twin' that shadow womens' experiences of receiving the gift of another child, of being an active participant in the birth of two children from one pregnancy, and in beginning mothering work with twins. This meaning also shadows the losses women experience when their pregnancy becomes a twin pregnancy that is designated as high risk. The importance of this work lies in its rich accounting

of what it means to become a mother of twins, where womens' bodies are not their own, womens' birth experiences are not their own, and the mothering of their infants is shared with others. In this accounting, health care professionals are called to reassess their actions as caregivers for pregnant women, especially for those who are having twins.

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Chapter One

To be a Mother

> *The woman conceives. As a mother she is another person than the woman without child . . . . Something grows into her life that never departs from it. She is a mother. She is and remains a mother even though her child dies, though all her children die. For she at one time carried the child under her heart.*
>
> *Meltzer (1981), p. 3*

In the past, a woman tended to accept or reject what nature, fate, or God had designed for her—children or childlessness—with little question. In more modern times, the advent of contraception and assisted conceptive techniques have introduced choice into a woman's life. Questions of *Will I have a child?* have become questions of *Should I have a child*? "Some women try to ignore the question of children; some put it off until it is too late; and others fear that with or without children life may pass them by" (Bergum, 1997, p, 28). Some women choose to be childless, while others choose to have children but remain childless. It is in asking the question *Should I?* that the pull of the mothering relation becomes apparent. When one asks, the thought of a child is already in one's mind. But to answer the question, a woman must make a momentous decision that perhaps "cannot be fully understood until the child is concretely in one's life" (Bergum, 1997, p. 30). One woman, who thoughtfully made a decision with her husband to have a child, but was still unsure about it, said:

> You *think* about it. You *think* you want to be a parent. You *think* that it will be a neat thing. You *think* it will give you the positive feedback that a career can give. But you don't know. You have to find out. (Bergum, 1997, p. 29)

Pin-pointing the exact decision-making moment of whether or not to have a child may not be possible, says Bergum (1997). It may be a result of many memories and experiences in a woman's life—enjoyable afternoons of mothering dolls as a child, the reminders of fertility that come each month with menstruation, the sounds and smells of a friend's newborn infant, the spectre of her own ticking biological clock. We may not be able to determine exactly what helps a woman to decide whether or not to have a child. Something brings the thought of life with a child into her consciousness, and makes the 'deciding' more urgent.

A woman may decide that the time is right to bring a child into this world. But "a decision without action is not a decision" (Bergum, 1997, p. 33). With the decision to have a child, a woman must take action so that the conceiving of that child is possible. Counting days, stopping the pill, removing her IUD, forgetting her diaphragm, no condoms, temperature taking, and lots of sex are ways that women act on their decision. Even in making the decision, and in taking action, second thoughts come up—fears, worries, and questions about what changes a child might bring to a woman's life.

Of course, making the decision to have a child, and acting on that decision do not guarantee that a woman will have a child. She may agonize over the decision, finally say "Yes I want to have a child" and act on her decision, but month after month, she does not become pregnant. 'Nothing' happens. Yet something does happen—menstrual blood appears. "Menstrual blood is the sign of hope and the promise of children. It is life blood" (Bergum, 1997, p. 31). Curiously, it is a sign that one can become pregnant, but also a sign that one is not pregnant. When a woman is

trying to have a child, the monthly appearance of her menstrual flow does not conjure up either hope or promise. It tells her that she did not conceive. For a woman who desires a child, it is the manifestation of her fear. She is wounded. She bleeds for the child that will not be. "That period is just like devastation. It's like hitting rock bottom. Everything you hoped for is gone"; "When your period came you'd cry", say infertile women, facing monthly menstrual flow (Harris, 1994, p. 59). Their desire and their actions were not enough to have a child.

Some women who do not conceive face other questions, other decisions. *Do I desire a child or my own child? To what lengths am I prepared to go to have my own child? In my desire to have my own child, do I seek assistance from reproductive technologies? If I do, what consequences might occur?*

> People don't actually realize the emotions you go through when you can't have children, when there's that option that you may not be able to have children and may never be able to bear your own children. Of course you're going to do everything possible to have those children even if it means taking fertility pills and even if it means ending up with three or four or five children at one shot. You'll do it because you want to have your own children.

Losing the customary body

With the desire to have a child, and in making efforts to conceive a child, a woman's bodily self begins to change. When I speak of the bodily self, I do not speak of the body as separate from the self, as "another thing in nature or an object among physical objects" (Stewart & Mickunas, 1990, p. 96), but as embodied—the self inseparable from, but not identical to, the body (Gadow, 1980). This body-self

relation, the lived-body, is our way of being in the world. It is "the consciousness of being capable of affecting the world, as well as the consciousness of being vulnerable to the world's impact" (Gadow, 1980, p. 174).

With the awakening desire to have a child, a woman's "unaware awareness" of her body changes (Van Manen, 1998, p. 11). Ordinarily, she is occupied with the world and being in the world with everyday projects like walking the dog, driving to work, shopping for groceries, reading, cooking dinner. Her attention is held by these ordinary things, and so her body goes almost unnoticed. The body is "passed-over-in-silence" says Sartre (Van Manen, 1998, p. 11), as her physical movements of walking, or driving, are overshadowed by the meaning that the drive or the walk has in her life. She experiences her actions as one with herself; she is her acting, and also has a "felt capacity" to be affected by the world (Gadow, 1980, p. 174).

As a woman's thoughts turn to having a child, a burgeoning awareness of this body of "near self-forgetfulness" (Van Manen, 1998, p. 11) shows itself. No longer is monthly menstruation just an expected cyclical event. It has added significance as an indicator of being 'pregnant' or 'not pregnant'. She becomes attuned to other things: the mittelschmerz pain of ovulation, or the changes in cervical mucus at mid cycle when ovulation is most likely occurring. Small things that she ignored months ago now have become important. She thinks about what her body might feel like if she were pregnant. Would her breasts feel tender in quite the same way they do just before she gets a period? Would the implantation of the fertilized egg feel like menstrual cramps? Would she still feel that tense irritability that comes just before a period is due? She has discovered her body, or as Van Manen (1998) says, "the body

reflects on itself as a body" (p. 12). A woman who desires a child begins to lose her "customary body" (Young, 1984, p. 49) as she contemplates pregnancy.

Assuming the encumbered body

With the disturbance in her relation to her customary body, aspects of a woman's body become conspicuous so that it becomes an object of reflection. She reflects upon the slight rise in basal body temperature. What does this mean? Am I ovulating? If I have intercourse today, would I get pregnant?

Van Manen (1998) has shown us that in illness, this conspicuous disturbance in body relation always stands before us in a confrontational way. We worry about the disturbance in a way that is disquieting to us. In illness, the body relation becomes encumbered in its dis-ease, in its un-easiness. To be encumbered is to be burdened, to be weighed down, to be hindered.[1] The body in illness assumes an "objectlike nature" as it stands before us (Van Manen, 1998, p. 12). We watch it; we worry over it.

Pregnancy is not *a* disease. But to desire a child and strive to become pregnant is to encumber oneself with wondering, worry, and dis-ease. We are not at ease with our way of being in the world. Am I pregnant? How will I feel if I'm pregnant? I wonder. The possibility of pregnancy is with her—did it happen or not? "From about the 27th or 28th day on I'd be looking for it [menstrual period] and it wouldn't come. And I'd think, Ah! Wow! Well, maybe I'm pregnant, and get a little bit excited" (Harris, 1994, p. 58). She waits, watches her body for signs that she has conceived a child, and wonders if her efforts at becoming pregnant have been successful.

---

[1] The etymological sources used to describe word meaning in the remainder of this work are: Oxford English Dictionary (1958), Skeat's (1993) Concise Dictionary of English Etymology, and Webster's Encyclopedic Unabridged Dictionary of the English language (1989).

> When it [menstrual period] comes, it comes. I kind of think that way but I kind of don't. You have to say like, I'm not going to worry about it. But yet, I am. Even to go for a pregnancy test or making love, in my heart it's just like, we're going to make a baby, or it's going to be positive. But yet, my mind is saying, don't do this to yourself. (Harris, 1994, p. 59).

Women's body relations are encumbered not only by unease with becoming pregnant, but by worries about never achieving a pregnancy at all. Questions of *What if it doesn't happen this month?* blend with questions of *What if it never happens at all?* With the objectlike nature of the encumbered body, a woman also may assume an oppositional relation with her body when continued attempts to conceive a child fail. Her body is not only an object to be watched, but a separate persona is assigned to her body, one that opposes her wish to become pregnant. "I felt like my body had failed me. I felt like my mind and body were not in sync" (Harris, 1994, p. 60). There is "body betrayal" in her failure to conceive (Hayne, 1998, p. 6). Her body seems to have a life of its own; it is she and yet not she. She lives in her body, makes decisions within her body about seeking to have a child, takes actions within her body to achieve her goal, yet her body has not behaved as she expected, has not cooperated as she wished, and has become less dependable, unpredictable, an object of uncertainty.

In their decision and quest to have a child, some women are burdened with additional worries. If I get pregnant, will the baby be OK? Will I get through it? Sometimes, friends or family members have experienced a loss during pregnancy, or during a birth, or even shortly afterward. "I know what it is like to give birth and to have a stillborn baby and, I mean, what is worse than that? Nothing" (Lever-Hense,

1994, p. 165). A congenital defect may have shown itself somewhere in her family history, prompting worries of *Could that happen to me?* In their decisions to have a child, women try not to dwell on the chance that something might go wrong. "You always think there's nothing going to be wrong with your baby, it'll be born normal. You don't want to think the opposite" (Diachuk, 1994, p. 228). Perhaps twins are a family trait, or the woman is a twin, and so her intergenerational risk of having twins is greater. "There are so many twins in our family. I have twin brothers, my mom was a twin, twins in my dad's family." If I do become pregnant, and something happens, could I handle it? What would I do?

During the time of deciding to have a child, and taking action to have a child, a woman is burdened, plagued, by these questions without answers. They keep coming back to her. She lives with not knowing—wondering if she will conceive a child, and if she does whether her pregnancy will be as she hopes it will be, and wondering too, if her child will be a healthy, normal child. At the same time she is weighed down by the conspicuousness of her body as she zeroes in on the parts and processes of her body that might give her clues as to whether she has conceived or not. Are her breasts more tender than usual? Has her cervical mucus changed? Is her basal body temperature staying elevated or coming down? And most tellingly, when is her next menstrual period due?

Easing the burdens of the encumbered body

Am I pregnant? Women who have been trying to conceive ask, and try to answer, this question. They attend to their bodies, and worry about the outcome of their decision to try to have a child. Some women begin to suspect that they might be

pregnant. Their period is late or is 'different', or they just 'feel' different. They self-diagnose—they are, or they are not.

> I can't believe it, oh no, I'm not pregnant. But then again I felt pregnant, feeling like I might be pregnant. It was some changes about me that I hadn't noticed before so . . . and I said, no I couldn't be, but then again I kept thinking I was. But that went on for one or two weeks, maybe three weeks. (Patterson, Freese, & Goldenberg, 1986, p. 107).

Women are weighted with worry about the possibilities of being pregnant—still encumbered, still attending to the conspicuousness of certain aspects of their bodies.

Their burden is eased somewhat by a positive pregnancy test. Even when women suspect they are carrying a child, a pregnancy test is confirming. As if technology is infallible, "a pregnancy test, in the eyes of patients, takes on status as 'the' criterion for a diagnosis of pregnancy" (Patterson et al., 1986, p. 108). "I figured you'd have to wait at least two weeks after your missed period before you got an accurate test. I didn't want to get my hopes up. There was no sense in going before it would show anything" (Harris, 1994, p. 68). Perhaps women feel a need to legitimize their suspicions about their body, a legitimization that will allow them to seek health care. We term health care for the pregnant woman *pre-conceptual care* and *pre-natal care*, as if one has access to the first only if they are not pregnant, and the second only if they are. Where does the woman who is not quite sure fit?

With the confirming pregnancy test, a woman's encumbered bodily relation changes. From suspecting, *I think I'm pregnant,* to affirming, *I'm pregnant,* some of the burdens of the encumbered body are eased. No longer is she focused on mastering

aspects of her body to become pregnant. Slowly, her fears about not being able to conceive are set aside. Her focus on identifying bodily indications of pregnancy wanes as she focuses on the generativity of her pregnant body.

Transforming to the generative body

With the news that she is indeed going to have a child, a woman can give the changes in her body a place in her life. The 'symptoms' she has noticed are not just discrete, unrelated bodily behaviors. Together, they add up to something, a new kind of self-knowledge. In receiving the validation of diagnosis, a woman now knows herself in a different way.

Does confirming a pregnancy differ from a confirming diagnosis of a disease, like cancer or multiple sclerosis? One wants to know, and that knowledge lives with the act of naming the bodily state that we are focused upon. Our diagnosing, be it pregnancy or a disease condition, grants a distinctiveness to some characteristics that we wish to classify. Once we classify these characteristics, they come together in a name, "we pay attention to it. We cater to its peculiarities" (Hayne, 1998, p. 3). For women who have conceived a child, the classification of the characteristics come together as 'pregnancy'. The name has a significance about it. The invisibility of a woman's 'symptoms' have become something that we can recognize.

With pregnancy, a woman can no longer "live past one's body" (Hayne, 1998, p. 5) because the diagnosis has given her a heightened sense of the body that she is, and also of the body that she has. She is no longer seeking to master her body and have it submit to her. She is pregnant, and she also looks at the 'parts' of her own pregnant body. Her arms, her legs, her belly, her breasts. But their changes are imbued

with the positive meaning of pregnancy. They are the "body's expression of its own determination, aim, or purpose" (Gadow, 1980, p. 180)—that of generativity.

As the generativity of her pregnant body shows itself in her changing form, a woman's sense of her body as objectlike recedes. That sense is replaced with what Gadow (1980) calls "a balance of form and freedom", an aesthetic relation between self and body, in which the pregnant body-pregnant self reciprocally develop one another, each aspect responding to the other freely. It is in the creative process of pregnancy that a woman is both the source of the process and a participant in the process. "Though she does not plan and direct it, neither does it merely wash over her; rather, she *is* the process, this change . . . . the body attends positively to itself at the same time that it enacts its projects" (Young, 1984, p. 46, 54).

In one sense the wholeness of her pregnant body-pregnant self works at the processes involved in generativity—being with child. In another sense, one cannot help but acknowledge that she carries another being within her, one that is separate from her, yet part of her. We look at pictures and diagrams of pregnant women in prenatal pamphlets, self-help books, and in the atlas of pregnancy. We see through the window in the diagram, can open the window into her body and view her organs and see the child develop week by week, page by page. So, she is her pregnant self-pregnant body, and also another. She is herself but not herself.

The generative body

What is it like to experience "pregnant embodiment" (Young, 1984, p. 45)? What is it like to have one's embodied self pregnant, full, fraught with before-birth meaning and possibility?

I am expecting a child. Time ceases to be measured by clocks or by calendar pages, as it was for me and as it is still for others. Time is measured with a nine month yardstick, beginning with some point zero, the moment of conception, and ending with the moment of birth some nine months hence. My knowledge of human reproduction gives a modern meaning to the waiting of expectation. While I feel impatient at times, I know that I cannot hurry up the process. Nature takes its expected course. Unless a disruption might occur, each week, each month, each doctor's visit, each landmark of the baby's growth and development, each pound gained or lost, is an important milestone on the way to birth. For the woman who is "expecting", the waiting experience itself may turn pregnant—filling up, heavy with before-birth meaning.

I reach for my fork and lean toward the table. My plate doesn't seem so far away but as I lean forward, I feel my abdomen compressed, its heaviness pressing on my thighs. My thighs support its bulk, the skin of myself touching the skin of myself. I look down and see my arms leaning on the table, and an abdomen that touches and just fits below the table--I cannot see my legs or my feet. The table feels too far away to eat, but I can't maneuver my body any closer, so I eat slowly and carefully. My abdomen presses inward on my stomach. I feel full, but it is not the fullness of eating too much. When I eat too much, my stomach presses outward, aching from being stretched. It infringes upon the space of its fellow organs, nudging the others out of their rightful position for a time. They rumble, grumble, and move aside. Slowly the stomach slips back into its rightful position and the ache recedes. Now, with each bite and each swallow, my stomach struggles to expand as if lifting a heavy weight that is

pressing down on it. Instead of feeling the fullness of eating too much, I feel the fullness of my body, pressing inward, compressing my organs. How is it that I feel my insides as smaller, yet my body is becoming bigger, occupying more space in my world? My clothes, and even my shoes, are larger. I struggle to get into, and out of, a car that I enjoyed driving just a few months ago. I attempt to squeeze through the empty space between two chairs in a restaurant, between two bookshelves and a person browsing in the library, without success. Inwardly, I sense a lack of space for my insides, yet outwardly I am getting bigger. What lies in the space in between the inside boundary that I sense and the outside boundary that I see?

The baby moves. My hand goes to my rounded belly, my entire hand, palm down, pressing lightly. There is the cloth of my clothing beneath my hand, but my hand doesn't feel it. There is the skin of my abdomen beneath the cloth, but my hand doesn't feel it. I touch the cloth and the skin beneath it, but I feel the baby. I don't take the hands of my husband or my sister and say "Here, feel my dress move, or feel my belly move." I say "Feel the baby" and gently place their hands on my abdomen, palms rounded, flat, as much of their palms to my tummy as possible, skin to skin, so they have a better chance of feeling what I feel from the inside. They touch my belly and they stare at my belly, but they don't see my belly, and they don't see me. They look past my belly, past my skin, past their hands, past me. They look intently to see who it is that is touching them. Their eyes are intent, but they look with their hands instead of their eyes. Their hands, splayed across my belly, palms down, fingers stretched, create a space large enough to enclose a newborn. When they touch my tummy to feel the baby move, their touch is light, gentle, tentative, afraid to hurt. They

touch my skin as if they already touch the skin of a newborn. They speak in hushed whispers, awe in their voices. "Did you feel that?" "Wow." "What does it feel like to you?" they exclaim and question.

The baby rolls. My hand feels my belly move outward, its contour changing. I sense what my hand feels, but at the same time I sense my abdomen being pushed outward from the inside and my organs compressed inward, making more room for the baby's gentle roll. The skin of my abdomen tingles as it is stretched. The baby quiets. I wait for more movement, my palm in position. Then I see it at the same time as I feel it--a push from within. The skin of my abdomen, beneath my hand, is pushed outward in one spot. As I sense the touch from within, my hand feels the outward movement of my skin, the pressure against the palm. I lift my palm and use my finger to gently poke and prod the tiny protrusion. For the space of a second, the protrusion is gone, the contour of my belly is symmetrical, and then I see it again and feel the pressure on that spot from the inside. I close my eyes and imagine a tiny foot pushing the walls of its dark world outward.

From my baby's touch from within, I begin to find its being. I distinguish my pregnant self from the self I was before I carried a child inside my body. When the baby touches me, I know that it is there, separate from me, yet enclosed within my body. With each touch, my baby reminds me that I am pregnant, that I carry a child, that I will soon be a mother. Buytendijk (1970) teaches us that touch represents communion in the human sense because the human being who touches or feels a touch finds the felt object as immediately present with herself. Is this not true of pregnancy? My baby kicks me under my ribs, stands on my bladder, erupts at loud

noises, sleeps, and then awakens in my morning. During these moments, I forget any other actions in which I am involved. Immediately, I stop, pause, and attend to my baby who, through touching me, is declaring its presence. My baby and I share the moments of touch, of communion.

Do I touch my unborn baby as I would pat the back of a crying child? Do I touch my baby as I would touch the hand of a neighbor? No, even before its birth, I touch my baby with care, the word from which caress is derived. My touch is slow, light, monotonous in its pressure and repetition, imbued with the irreplaceable quality that Buytendijk (1970) calls "etre a deux" (p. 116), when "the being of the self opposite the being of the other are present in one single touch becomes by the caress a being-one-together" (p. 116). Through touching, caressing, and receiving that caressing touch, my baby and I are brought together symbiotically, in "etre a deux". We are a complementary whole.

I sit quietly in a rocking chair, looking at nothing. My hands rest lightly on my protruding abdomen, one below and one above, palms to skin, as if holding and supporting its bulk. My hands lightly move back and forth across my belly, delicately stroking. Through the skin of my palms and the skin of my abdomen, through the muscles and the uterine wall, I feel the presence and the nature of the form of my baby. As I feel the rounded contour of my belly, I discover the dimensions of the space my baby inhabits, the position in which it lies, and I begin to construct its form. My belly becomes an examined object, by its very presence and its resistance to the activity and movement of my palms, participating with me in the discovery of itself and of the baby beneath it. My palms touching belly, then, become the "point of

departure" according to Buytendijk (1970), "of an intentional feeling, an affinity, a profound understanding, a being moved, struck emotionally by what is touched, which manifests its presence in its 'quale' [how it is], its matter, as an independent existence" (p. 114). Through this point of departure, this discovery of the outside limits of the space which my baby occupies, I form increasing ties to my baby, and "crossing these, a differentiated, ineffable knowledge" (p. 114) of what lies beneath my palms, and within my body. Through touching my abdomen, I begin to find my baby. "Touch transmits from the flesh to the flesh the pulsation of life— the communication with a foreign destiny" (Buytendijk, 1970, p. 115). Through touching my baby, and my baby touching me from within, I sense what changes are taking place within my body, and can clearly imagine the imminent birth of my child.

Moving to the edge of the rocking chair, I place one hand on the arm of the chair. I struggle to stand. My body feels heavy, my centre of gravity lowered to my abdomen from where it had seemed to lie in my head months ago. I push my belly out of the chair and upward, dragging the rest of my upper body along. I stand and turn, my tummy always first. I see my image in the mirror opposite, my feet spread and my back swayed to support the added weight in my trunk. I walk towards the mirror with slow careful steps, my eyes fixed on my reflection. I feel the weight of the baby in my hip joints, and pressure in my pelvis with each step. Is this me? I turn from side to side, both hands molding the shape of my belly, the space of my baby, my eyes following the movement of my hands. It is me, and yet not me. I see my face, but a face that is fleshier in the cheeks, skin darker on the cheekbones. I see a body that protrudes in front, blocking its own movement. Swollen breasts, swollen fingers,

swollen ankles. A hard, round, middle has replaced my waist. I strain to supplant the image that I see in the mirror with the image of myself months ago, but that image eludes me. I see me, and I see my baby enclosed by me, together in a single body. It is the baby within me that makes my body, and makes me, what I see reflected now in the mirror. I do not see the boundaries of my baby's body within me. I see only the shape and size of my baby reflected in the shape and size of my own body. My pre-pregnant body, my customary body, with its distinct inner and outer boundaries, is lost to me. I lean over to pick up my shoes, a towel, or the newspaper, and I am surprised by the graze of my hard belly on my thigh. My movements seem to retain the old sense of my body boundaries. I live now, and must move in, a heavier, bulkier, pregnant body, but the habits and expectations of my customary body have not deserted me (Young, 1984).

Walking into a room, I meet the eyes of others. I see their eyes leave mine and slide down over my body, stopping at my protruding belly. Some shake my hand, some inquire about my baby. Sometimes someone asks "Can I feel your baby?" To them I am me, and I am also my baby, two distinct and separate entities. They speak of me and of my baby as separate individuals. But am I not also us, my baby and myself? We are so obviously together, part of each other, part of the same body. Sometimes it feels as if my pre-pregnant self lives in my body, with my baby, and other times I am this pregnant self, which is the combination of my baby and myself. My husband tells me about his day, inquires about mine, shares his thoughts and ideas, as he always does. Yet he also speaks to our baby, calls him by invented names, asks him what he is doing, and what games he is playing. He accompanies me to doctor's visits,

encourages me to eat nutritiously, and ensures that I take my vitamins. So, he talks to me, he talks to my baby, and he talks to my pregnant self. In pregnancy, I am a separate other, as well as a complementary whole composed of my baby and I, each dependent on the other in order to be one?

While I am pregnant, everything that is pregnant about the world presents itself to me. When I go shopping, I see pregnant women everywhere. In every elevator I enter, I stand next to a pregnant woman. I constantly drift towards the maternity clothes section in the stores. Why do these things, unnoticed until my own pregnancy, present to me in this manner? Why am I inundated with reminders of pregnancy when I am pregnant? Will they all disappear when I am no longer pregnant? Bergum (1989) uses the words of Van Manen when she speaks of women being "exercised" into motherhood through pregnancy (p. 62). When I notice a pregnant woman, or see a newborn baby, my own pregnancy and my unborn child are brought before me. When I eat the right foods, when I comply with my doctor's directions, I am practicing the care of my child by caring for my pregnant self, baby and self, during pregnancy.

However mundane the physical sensations of pregnancy may be . . . the hiccoughs, the rolling, the tumbling, the stretching, the startles in reaction to sound . . . in the end, they seem to prompt questions that are unanswerable. They bring me face-to-face with the experience of encounter. What comes to meet me in the encounter is a "striking and disconcerting actuality that strikes at the core" of my being (Bollnow, 1972, p. 306), an actuality that my baby is just as he is, and does not ask whether this is agreeable or disagreeable to me (Bollnow, 1972). My unborn baby lives within my body; his contact with me, his touch, is independent of my whims and

desires. When he moves and touches me from within, I experience the unpredictability of his nature, and the impending otherness of my baby in relation to my self. The experience of pregnancy is an encounter with the variable essence of another human life. Through such an encounter, this unborn being steps into my life as one of the aspects of its expansion. My life expands in this constant encounter. And this encounter with my baby leaves me enriched, aware of the inevitable end of pregnancy, and shaken at the inexorable mystery of life.

Chapter Two

The Question

I keep having this dream
where the women I love swell up like melons, night after night.
It's not surprising, really.
They've reached that age
where a woman must decide once and for all,
and this summer, most of them are pregnant.
Already their eyes have changed.
Like those pools you discover once-in-a-while,
so deep within themselves
you can't imagine anything else swimming in them.
The eyes of pregnant women. The women I love
fallen into themselves, somehow, far beyond calling,
as if whatever swims in their bellies
were pulling them deeper and deeper.

Wallace (1978), p. 230-31

For a time in my life, everyone seemed to be pregnant. I remember the excitement of getting phone calls from friends. Their news always seemed to start with a question, "Guess what?", barely repressed excitement in their words. I seemed always to know the answer to the question before they proudly uttered the next words, "I'm pregnant". I found it interesting that no one ever acknowledged their partner's part in this event. That phone call seemed like some rite of passage to me. From the moment they told me their news they were changed somehow. At first I always thought that the changes were only theirs. They talked about diaper pins and layettes and birth plans. They drank two glasses of milk every lunch break. They never stayed up late. They didn't want to ski anymore. But then I began to believe that not only had they changed--after all they did have another person inside their bodies--but the manner in which I treated them changed as well. I listened to them talk about topics

that held no interest for me. I asked them about their diet, asked them if they needed a nap before we got together for the evening, talked about weight gain, calcium replacements, and Lamaze classes. Sometimes, when we would sit together, it was difficult to reconcile the image of my friend before me, talking just the same, looking just the same, yet so changed by the process inside her. It intrigued me that these immense changes could be hidden so well in early pregnancy. Pregnancy, the big secret. If you didn't tell anyone about it, no one knew. The changes going on inside were hidden by layers of muscle, organs, and skin. Even later when my friends started to 'show', what was happening inside their bodies was still hidden. All I could see on the outside was a change in body contour, an increase in their body weight, and a change in their gait. I began to be fascinated by what I could not see. What was happening to them under that facade of skin?

When a woman expects the birth of a child, she experiences pregnancy. To speak of expecting is to speak of waiting for an event to occur. Pregnancy, *prae gnas*, means 'before birth'. Expecting a child is a certain kind of waiting: a waiting for birth. Expectation is "how we wait", a subjective aspect of waiting, says Fujita (1985, p. 108). With expectation, there is "a strong inner activeness in spite of outer passiveness: there is a belief in the occurrence of the expected event; and the expected event is sensed to be imminent and clearly imagined" (Fujita, 1985, p. 109).

A pregnant woman may be perceived by others to be outwardly passive--waiting for birth, expecting her child. What is seen on the outside is a change in her body appearance. As her baby grows on the inside, confined by parameters of muscle, bone, and organs, the outside of her body becomes bigger, bulkier, heavier. The baby

declares its presence to others by pushing itself out into the world. But the slowly occurring changes that others see on the outside do not reflect the inner activeness of this time of expectation. Inwardly, a woman moves from being a woman-without-child to a woman-as-mother. Pregnancy is the time in between these states, the time of being *with child*. Vangie Bergum (1989; 1997) calls the time of being *with child* a primordial relationship, "a mysterious union," "a commingling, an entangling, an interlacing that goes beyond companionship", where mother and unborn child are one, "an indissoluble whole, yet two, a mother and a child" (1989, p. 53).

I am intrigued by the incongruence of pregnancy's outer passiveness and its inner activeness. The texture and continuity of skin--what we look at, see, touch--on the outside seems to belie the changes occurring on the inside. The deceptively simple wholeness of skin covering a complexity beneath. And what physical complexities we know to occur during pregnancy--the blood communication with another individual, the growth and development of a person from the cellular level to that of organ maturation, the genetic disposition and future potential of a new human being. Biological marvels, yes. Yet, as we focus on these, are there others--just beyond these--that have not been wondered at, questioned, brought into the open?

"Do you hear this heartbeat? Do you hear this?" I listened. My body was still. As my ears became attuned to the muffled sounds of the doptone, my eyes became unfocused, unblinking, staring. My being strained to hear beyond the galloping sounds coming from the doptone, trying to sense more than what I could hear. A part of me marvelled at both nature and technology. I remember thinking that this was the first time that I had heard the baby's heartbeat. It was such a strong, measured,

perfectly cadenced, reassuring sound. I knew just a little more about the baby now, but at the same time I wanted to know even more. "Those aren't the same heartbeats," the physician said. I looked blankly at him. "I am 99.9% sure that there are at least two babies in there." My world seemed to shift, and resettle in a different place.

Through a woman's barrier of skin, I can determine some of the secrets of her pregnancy's inner activeness. The lie, the presentation, and the position of her unborn child--aspects of pregnancy that I cannot see, but which can be determined from an intentional touch of a woman's pregnant belly. Sometimes, through that same touch, I can probe other secrets of her inner activeness, such as the presence of more than one unborn child. Instantly, my sense of the woman's pregnancy changes--the enormity of the complexities of her inner activeness strikes me. She is 'having twins'. She carries two unborn children, not one, within her body. Somehow, the complexities seem to have more than doubled. What is happening beyond the outer passiveness of this woman's pregnancy? What is it like to be pregnant with twins?

Looking back, questions about twin pregnancy and twins seemed to gradually invade my work world, even as they had invaded my personal world. Over and over I encountered women who were pregnant with twins, who were birthing twins, or who had just had twins. I was fascinated by their stories, the experiences that they shared with me. I was intrigued with their adamant claims that "this pregnancy was so different". How was it different ? What was it like? Over and over I watched their eyes look inward when they answered. Some could compare it to a previous singleton pregnancy, while others could not. They spoke of their pregnancies with fascination, wonder, and astonishment. Emotions similar to women with a single child, yet always

a note of bewilderment crept into our conversations. How could there be two? "One, yes. That is a miracle in itself. But two? Amazing, unbelievable," women would say.

I watched and listened to health care professionals speak to women about their pregnancies. Weight gain, physical limitations, risk factors, and birth options were outlined as they are with any pregnancy. Yet their words seemed to reflect the notion that two fetuses had merely an additive effect on a pregnancy. "You are expecting two babies, so you need to not only increase your intake of certain foods, but you need to have even more of these. In a single pregnancy most women gain 20-25 pounds. Women with twins should gain approximately twice that much weight. You need to rest more, stay off your feet, quit work earlier than you had planned. You are considered to be having a high risk pregnancy now. You have a greater chance of experiencing premature labor, so bed rest in the second trimester of the pregnancy may be necessary. You may be able to deliver these babies vaginally, but a Caesarean section might be necessary."

Instead of addressing these pregnancies as situations of increased complexity on more than the physical level, health care professionals seemed to feel that women either should adjust their actions positively (more food, more rest) or negatively (less exercise, less work, less stress) to 'get through' the pregnancy. The outcome suddenly seemed more important than the pregnancy. But what happens to a woman during that time of pregnancy when she is deeply imbedded in her life as a woman who is 'having twins'? What happens to a woman between her frequent visits to the health care professional for prenatal appointments where her weight, blood pressure, urine test, fetal heart rate, and physical complaints are so precisely documented? What is

the nature of her inner activeness? How does a woman sense and imagine two babies within her self? How is the idea of 'twins' manifested in our world? What does it mean to a woman to be 'having twins'?

Studying the twin pregnancy experience

Previously, I have studied women who were pregnant with twins, proposing a grounded theory of the stages women move through from receiving a twin pregnancy diagnosis until the time of birth (Van der Zalm, 1994; 1995). This study captured the action/interaction strategies and evolving processes dominating womens' movement through a twin pregnancy. After completing this study, questions about womens' experience of twin pregnancy continued to plague me. Although the grounded theory was a beginning understanding of women who were pregnant with twins, I felt that a depthful accounting of their experiences and the meaning these experiences hold was lacking. At first, I hesitated to pursue further research that, because of my own two twin pregnancies, was so 'close' to me, but I felt a pressing sense of unfinished business—there was more to be learned.

To question is to already have a sense that one does not know, and that one seeks to understand. Understanding begins, says Gadamer (1989), "when something addresses us" (p. 266). We have a question *of something.* The intent of asking a question then, is to "bring into the open. The openness of what is in question consists in the fact that the answer is not settled . . . . The revelation of the questionability of what is questioned constitutes the sense of the question" (Gadamer, 1982, p. 326). By revealing the questionability of something, it is brought into a state of indeterminacy. Such is the paradox of the outer passiveness and the inner activeness of twin

pregnancy. What we once viewed as simply 'pregnancy', we now see as indeterminate. Our sense of indeterminancy surrounding twin pregnancy has been brought into the open. Answers about twin pregnancy are not settled. "A question presses itself on us; we can no longer avoid it and persist in our accustomed opinion" (Gadamer, 1982, p. 330). It is when a question is brought into the open that one realizes the undetermined possibilities of any particular thing.

In seeking to understand the experience of twin pregnancy, I do not attempt to prove a theory about pregnancy, predict a particular manifestation of pregnancy, or solve a problem about pregnancy in the manner of the deductive approaches of the natural sciences. Instead, I take a hermeneutic-phenomenological approach[2] in which I seek to articulate the essential meanings in the "human encounter" with women who conceive, carry, birth, and mother twins (Langeveld, 1983, p. 6). This is not meant to be a definitive work on this topic, but is intended to open a conversation, to pose meanings that are shared (Gadamer, 1989), and to "evoke in the reader a new way of understanding themselves and the life they are living" (Jardine, 1992, p. 60). Using an interpretive approach means that I, as a mother of twins, as a maternal-child nurse, and as a beginning researcher, with my individual, social, and historical life circumstances, my pre-understandings, perceptions, and prejudices, am intricately a part of this work (Bergum, 1991; Drew, 1989; Walters, 1996). I acknowledge that all of these things make this work what it is, yet I am not able to isolate the effects of

[2] Some philosophers make distinctions between phenomenology as pure description of lived experience and hermeneutics as interpretation of experience via a written text or some other symbolic form such as art, yet others argue that all description is ultimately an interpretation of that which has been described, says Van Manen (1990). In this inquiry, the terms interpretive and hermeneutic-phenomenology will refer to both descriptive and interpretive elements.

each on this work. I can only be aware that they are with me, that they bring me to this question, and use 'my self' to converse about the topic, re-generate meaning, and keep the conversation going (Smith, 1988). As Jardine (1992) says:

> Living with this instance and following its ways, and engaging in my own life and the life of others in an attempt to understand it has changed who I am and what I understand myself to be. New possibilities of self-understanding have opened up: old ones have been renewed and transformed (p. 60).

Within this work, I become changed as my understanding changes.

I have written this work to mirror the changes in my own understanding of the topic. The first two chapters have brought me to a sense of the questions I have about twin pregnancy and the mothering of twins. In Chapter Three, I delve deeper into the nature of interpretive work and how this type of inquiry contributes to the understanding of a topic. I set the stage for presenting my inquiry by discussing how I sought to answer my questions. Some individuals have misconceptions about the nature of twinning and the language surrounding the use of twin terminology. Therefore, in Chapter Four, I outline the pathology and incidence of twinning, the factors predisposing a woman to a twin pregnancy, and briefly address the nursing research about twin pregnancy and birth. To open up our past history and our present culture related to the phenomena of 'the twin', in Chapter Five I present interpretations of myth and legend, literature, films, and science. Chapters Six and Seven present my interpretations of the twin pregnancy and birth experience. In Chapter Eight, I write four womens' stories of loss that occurred during twin pregnancy and birth. Chapter Nine addresses the work of mothering twins in the early

post-pregnancy period. In conclusion, Chapter Ten highlights the transformation in understanding that has occurred as a result of this work.

Chapter Three

Understanding Twin Pregnancy

> *To reach an understanding . . . is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were.*
>
> *Gadamer (1989), p. 379*

In this work, I sought to understand: What is a woman's experience of being pregnant with twins? What does it mean to a woman to move toward the simultaneous mothering of two infants? What is it like to be 'having twins'? Rather than addressing theoretical formulations, making predictions, or hypothesis testing about pregnancy, I wanted an approach in which I could inquire into womens' experience of twin pregnancy and attempt to articulate both the meaning that these experiences have for them, and the significance that 'twins' have in our world. I looked to human science traditions.

Understanding as Being[3]

Descriptive and interpretive research approaches of the human science tradition are grounded in the philosophical writings of European scholars like Husserl, Heidegger, Merleau-Ponty, and Gadamer. The aim of such work is to systematically uncover and describe phenomena in their fullest depth and breadth. This uncovering and description of human phenomena reveals the character of the subject and the meaning of everyday experiences (Burch, 1989; Hammond, Howarth,

[3] An earlier version of the historical aspects of this section has been explored in: Van der Zalm, J. E., & Bergum, V. (accepted for publication July 1998). Hermeneutic-Phenomenology: Providing living knowledge for nursing practice. Journal of Advanced Nursing.

& Keat, 1991), "human actions, behaviors, intentions, and experiences as we meet them in the lifeworld" (Van Manen, 1990, p. 19).

Edmund Husserl (1965), often identified as the original scholar of phenomenological research, focused on three elements in his writings: subjectivity (perceptions of personal experiences), intentionality (subjective particulars pointing to larger phenomena or universals), and positivism (the means towards the acquisition of final or absolute truths about human experience). He aimed at finding an approach where an understanding of the 'essence' or 'eidos' of any given phenomenon could be determined, the "universal and immutable truth lying at the heart of every feature of human experience" (Hallett, 1995, p. 57). Martin Heidegger (1962) gave phenomenology a strong interpretive turn by focusing on the notion of Being as being-in-the-world uncovered through the analysis and interpretation of language and text. Merleau-Ponty (1962) argued that Husserl's bracketing of personal experience was not possible, and that being-in-the-world means that one is part of the experience. Rather than 'bracketing' out one's own preconceived notions about the subject under study, the researcher must become more conscious about those assumptions. Gadamer (1989) agreed with Merleau-Ponty on the issue of bracketing, and he explored language, conversations between people, as the way to understand our being in the world.

As I read, I began to realize that I was most comfortable with the philosophic assumptions underlying phenomenological approaches that are associated with interpretivism (Heidegger, Merleau-Ponty, and Gadamer) rather than positivism (Husserl). I balked at (and still do) Husserl's notion of essence as immutable truth,

and from his concept of a world, other than the natural world, "from which all things sprang" (Taylor, 1995, p. 69). Although I asked a question, What is it like?, that could be answered from either perspective, a Gadamerian approach held particular appeal to me for several reasons.

First, Gadamer's approach to answering this type of question is based on the ontologically focused Heideggerian phenomenology, and so it is centred on the concept of understanding as a way of being in the world rather than as a way of knowing about the world. The knowing-subject in apposition to the object-of-interpretation debate is discarded in favor of researcher and subject participating in the world together (Annells, 1996; Koch, 1996; Palmer, 1969; Pascoe, 1996; Walters, 1996). "Interpretations are not generated in individual consciousness as subjects relating to objects, but rather are given in our linguistic and cultural traditions and make sense only against a background of significance" (Pascoe, 1996, p. 1310). I, as the researcher, stand with those who participated in this inquiry, each taking a part in interpretation, each bringing our own social, cultural, and historical context into the inquiry. It is within this coming together in the inquiry, in this fusion of our horizons, that what is valued and what is significant about a topic of interest becomes visible (Gadamer, 1989). This fusion of horizons, a "coming together of different vantage points" (Koch, 1996, p. 177), occurs within a process of moving between a background of shared meaning and a focused experience within it—between the whole and the part.

Second, in using Gadamer's hermeneutic approach for this inquiry it was not necessary for me to bracket out my world and any preconceptions I may have about

the topic of interest (if indeed this is even possible). As ontological preconditions necessary for all understanding, my preconceptions and prejudices become part of my interpretation (Koch, 1995; Walters, 1996). "Interpreting our world in the light of our pre-understandings is indeed a universal feature of human life" (Pascoe, 1996, p. 1311). As a maternal-child nurse, one who has experienced twin pregnancy, and one who is interested in the topic of twin pregnancy, I can utilize my pre-understandings as an adjunct to self reflection and self understanding. My prejudices and pre-understandings from *my* social, historical, and cultural context are part of what my interpretation becomes.

Lastly, in coming to understand the experience of twin pregnancy phenomenologically, I wanted not just to provide a descriptive account of the experience, but to be able to provide an impetus for changing pregnant womens' health care for the better in some way. I agree with Martin Packer (1989) who says: "Hermeneutic research is tied to an appreciation that a 'better' account is one that at the very least fosters our understanding and clarifies our action" (p. 117). Interpretive inquiry, by the nature of its attempts to foster understanding through interpretations that encompass our values, our emotions, and our history, is fundamentally tied to actions that are grounded in the everyday world in which we live. By questioning in an interpretive manner, we are opening up the actions of our everyday world with a moral force. In coming to a different understanding of the 'what' of the topic, we begin to ask 'why?' (Packer & Addison, 1989). After questions of 'why?' come questions of 'are you sure?' It is within the attitude of the question 'are you sure?' that one becomes attentive to what is needed for ethical action, for what should be

done in particular situations (Van der Zalm & Bergum, accepted for publication).

The Dialectic: Transforming our Understanding

Hermeneutics, from the Greek *hermeneuein*, to interpret, and *hermeneia*, interpretation, is associated with Hermes, the wing-footed messenger of the Greek gods. Hermes, also known as 'the trickster', was to transmute (via language and writing) what was beyond human understanding into a form that human intelligence was able to grasp (Palmer, 1969). Although contemporary hermeneutics is associated with a broad range of theoretical and practical approaches aimed at interpretation, its concern remains with the "Hermes process", that is with language and how language functions so "something foreign, strange, separated in time, space or experience is made familiar, present, comprehensible" (Palmer, 1969, p. 14). Literally, within the Greek translation of *hermeneuein*, three meanings emerge: to say, to explain, and to translate (Palmer, 1969).

To inquire in an interpretive manner, one "wishes to playfully explore what understandings and meanings this instance makes possible" (Jardine, 1992, p. 56). One engages in a continuous dialogue with others, with written texts and references, with oneself. One questions, explores the answer, continues to question, and continues to explore. Each question and each answer enables our next question to take on a different form, to push our questioning in a different direction. With persistent questioning and a continued orientation towards openness, one can continue to explore the phenomena of interest. This is the art of conducting a conversation, a dialectic, referred to by Gadamer (1982) as "the art of thinking" in the hermeneutic sense (Gadamer, 1982, p. 330). In this conversation, one brings out the strengths of

what is said in an attempt to articulate a common meaning: "language, in the process of question and answer, giving and taking, talking at cross purposes and seeing each other's point, performs that communication of meaning which, with respect to the written tradition, is the task of hermeneutics" (p. 331). It is as we interpret and question, reinterpret and question again, in a continuous manner, that what is meaningful to us is sensed and can be articulated. "This is the reason that all understanding is always more than the mere recreation of someone else's meaning. Asking it [the question] opens up possibilities of meaning and thus what is meaningful passes into one's own thinking on the subject," says Gadamer (1982, p. 338). Thus, our past understanding has been replaced by our present. The horizon of what we understand has opened, become wider, farther, and now we can question and converse about the phenomena of interest from a different perspective than previously. It is in this continuous widening of our horizon about a phenomenon that our understanding of it changes.

"To the extent that interpretation makes things readable, it is intimately linked up with a sense of literacy" (Jardine, 1992, p. 56). The manner in which we ask the question about what addresses us, the words we use, the language of conversation about a particular instance, the ways we connect this and that—all are integral to the understanding of the meaning of a particular phenomena in our lives. They are the medium for our understanding of our life in the world. They reveal our being (Hekman, 1983). With and within these, we begin to discover a sense of what is shared between us, "the analogical kinships of meaning", the "family resemblances", which we can bring forward in conversation (Jardine, 1992, p. 59). The give and take

of conversations transform our understanding of ourselves and of our lives. We understand what initially addressed us "differently, more deeply, more richly" (Jardine, 1992, p. 60), and with this transformation comes new, but undefined, questions, understandings, and directions.

This inquiry places the concreteness of an experience in the world that we live in together and tries to orient its particularity to what is given to us in the world. *Verstehen*, a "communicative and interpretive understanding . . . a partaking in common meaning" (Van Manen, 1977, p. 220), a recognition of another's pre-reflective experience in the world, can result because of a sharing of history, culture, temporality, and language. We look at possible claims of how the experience, the topic of our interest, is presented to us. This is the hermeneutic truth, *alethia*—the opening up, the uncovering of something hidden about an experience. With this opening up, our understanding of an experience is transformed from what it was to what it is (Jardine, 1992; Packer & Addison, 1989).

Researching the twin pregnancy experience

One of the most intriguing facets of interpretive work is that it is distinguished by a lack of prescribed method. Rather than strict adherence to a particular method, hermeneutic-phenomenological approaches are grounded in "a body of knowledge and insights, a history of lives of thinkers and authors, which, taken as an example, constitutes both a source and a methodological ground for present human science research practice" (Van Manen, 1990, p. 30). The interpretive researcher, in remaining orientated towards the question at hand, selects or invents techniques, methods, and procedures that will assist in fulfilling the aim of the inquiry—to

understand the significance and meaning of the experience more richly, differently.

To be a phenomenological researcher, says Bergum (1991), one must attempt "to push off method for method's sake, to push off sureness and become unsure, to resist conceptual analysis with a view to explain" (p. 61). One must develop an openness, an attitude of seeing the world as one filled with interpretive possibilities, and one must develop a comfort with ambiguity and be prepared to become engaged with all of the "messy secrets" of living in the everyday world (Jardine, 1997, p, 161).

As a beginning researcher, I embraced the tenets of interpretive work. I could work within the philosophical framework. It felt right for me. It was exciting and intellectually challenging. Yet, looking back, I now recognize that even with the feelings of freedom I had about working within an appealing philosophical framework, there was also an uneasiness. I began to realize that I was uneasy because a *particular* way of doing things, the comfort of a plan, was not in place. I knew where I was starting and I knew where I wanted to go, but what lay in between was a blur. I had to *learn* to accept the uneasiness as part of the process of doing research in this way. I had to let the inquiry lead me. And then write about where I was led.

Beginning

To find out what the experience of twin pregnancy was like, I wanted to talk to women who had twins or were expecting twins. To access this group of women, I wanted to place an advertisement in the publication of the local multiple birth support organization (see Appendix A). First, I had to meet with the executive of the organization, present my research plans, and answer their questions. They would vote on whether the information about this project could be included in their publication.

The meeting was held at the home of the president of the organization. I presented my research plans to a room full of women. I answered their questions, and they voted in favor of including my information letter in their publication. I gathered my things in preparation to leave so they could continue with their meeting agenda. While I was putting on my coat, the women began to talk about their pregnancy experiences, their feelings about having surgical births and other birth interventions, their experiences of taking their twins home, and their thoughts about their identities as mothers. Two women came up to me as I stood at the front door and gave me their names and phone numbers, asking to be a part of the study.

Thoughts raced through my mind: Could I actually take their names? If I did, was that ethical as all of the women in the room heard them ask about participating in the study? The conversation I was overhearing was completely spontaneous—I didn't have a tape recorder, and these women weren't enrolled in the study!! Could I listen to what they were saying? Could I *use* what they were saying? I lamented: This was not the way it was supposed to be!!!

I left the meeting. I had with me the names of the two women who wished to be participants in the study. I went home and began my research journal—was I doing the right thing? Was it OK to be writing about what happened that evening? In these questions, I realized later, lay my own struggle, my own baggage, in coming to terms with the nature of interpretive inquiry. It was only as I thought about my own reactions and my own questions about the evening that I began to understand what I had read and embraced so blithely a few months before. Not only was I getting a first-hand example of how I was a partner in the research process, not controlling it,

but on another level my own understanding of interpretation and interpretive research was in itself being transformed. *I* was just like the researcher in David Jardine's (1997) "Messy Secrets" paper, who didn't think she was ready for the 'data collection' stage when she was right in the midst of it all along! To engage in the practice of interpretation is to be open to possibilities for transforming understanding, however and whenever they may be presented.

Accessing sources

Multiple sources have contributed to this work. Conversations with women who had a twin pregnancy experience were undertaken. Mythological, historical, biblical, literary, and cinematic sources were accessed for any work that might help to better understand twin pregnancy. I attended lectures about twins and watched films about twins. Friends and colleagues sent me newspaper clippings about multiple births and twins. Whenever I went to the bookstore, books about twins seemed to appear on the best seller list and on the shelves in front of me. I attended community functions where women that I did not know came up to me and told me stories about themselves and their twins. I could not accommodate all of the women who contacted me and wished to be interviewed as a part of this inquiry.

Conversing

Thirteen women talked with me on an individual basis about their twin pregnancy experiences. Of these, seven were pregnant at the time of the conversations: Four women were carrying twins; one woman was carrying a single fetus, the living partner of a vanished twin pair; one woman was carrying one live twin and one twin who had died; and one woman who had two previous twin

pregnancies was newly diagnosed as pregnant and did not know whether the pregnancy was a singleton or twins (a single pregnancy was confirmed many weeks after our conversation). Any quotes used in this work that are not referenced to another source are the words of these women participants.

I speak of these meetings with women as conversations rather than interviews, as I approached this process in the same manner as Bergum (1991) who says, "Like an interview the conversation has a central focus, but it is not one-sided" (p. 61). Rather than one person (me) asking the other specific questions about something in a formal situation, we came together to discuss a topic. The attitude of the conversations was informal. Conversations with individual women took place at a location convenient to them. Most often this was in the woman's home, but other locations were a hospital room, my home, a room in a university building, and in the workplace of one woman. Our conversations began with the 'business' of the research project: Reviewing the information letter, reviewing ethical considerations, and establishing consent. Biographical data was obtained following consent (see Appendix B). I collected the biographical data to further describe each woman.

At the beginning of our discussion about the twin pregnancy experience, I focused the conversation by saying: "Tell me about your experience of twin pregnancy. What was (is) it like for you?" On many occasions, women would describe their experiences at length with little or no interruption by me. I would prompt them by nodding, sometimes attempting to have them describe something more deeply by asking: "Can you tell me more about that?" The women who spoke with me needed little encouragement to share their experiences, a finding also noted

by Bergum (1991) in her studies on mothering. Although our conversations focused on their experiences, not mine, in keeping with the inquiry and its aim, I was deeply involved in each conversation by the nature of my interest in the topic, but also as one who could recognize elements of our common experience. At times I felt that our conversations were validating of my self as researcher and of my research work as, even though the direction of the conversation was led by the woman, they spoke of many aspects of experience and process that I had studied previously.

Of the thirteen women participating in individual conversations with me, I met with four of them on more than one occasion. These women were pregnant at the time of the first conversation, and I spoke with them at approximately one month intervals during their pregnancy, and on one occasion post birth. Conversations after the birth of the twins were more difficult to schedule. During three post birth conversations, the babies were present with us in the room, and both their mother and I tried to keep them content while we talked.

Seven women met with me in one group conversation to discuss the experience of twin pregnancy. Several of these women had participated in an individual conversation with me, and were also interested in speaking within a group about their experiences. All of the women who participated in the group conversation had been pregnant with twins previously. The group conversation proceeded in a similar fashion to the conversations with individual women. Details about the research and the facility were discussed (see Appendix C and D), consent was established, and then I obtained biographical data from those involved.

To focus the conversation in the group on pregnancy and to give everyone the opportunity to speak, I asked: "Can each of you tell me one change in your life that occurred when you found out you were pregnant? Let's go around the table to my right." The next question focused the conversation on twin pregnancy and was not directed to any woman in particular: "Can you tell me one change that occurred in your life when you found out you were pregnant with twins?" The conversation mushroomed from that point. My verbal involvement was minimal, except again, to ask (when I had the opportunity!): "Can you tell me more?" or "Can you give me an example?" At the close of the group conversation, terminated after two hours and fifteen minutes because the participants had child care responsibilities, I asked each woman to respond in writing to a poem about pregnancy that I read to them. I wanted to attempt to access memories of their pregnancy experiences that might be evoked by a poem about pregnancy. I read Wallace's (1978) *Melons/At the speed of light* (see Appendix E) to them and then asked each woman to think about the poem and complete the following sentence: *When I was pregnant I remember* . . . . After five minutes in which to write, each woman gave her written response to me. I made copies of each, and mailed her own original response to each participant.

At the close of the interview, several women approached me to show me keepsakes of their pregnancy and birth: Poems that they had written, photo albums, photos. They wanted me to have copies of these precious possessions. One woman had only two photos taken with an instamatic camera of her 700 and 750 gram babies. She entrusted them to me so I could make copies—she was worried that the color

might fade and soon we wouldn't be able to see them, their image as they were would be lost. A week after the interview I received a card in the mail from one woman—inside the card was a photo of her twins as babies. All of the women who participated in this inquiry asked me to contact them again if they could be of further assistance to this or any future inquiry about the experience of twin pregnancy. Child care and parking expenses of women who attended the group conversation were paid.

Analysing

All of the conversations were transcribed by a secretary. After the transcribing, I reviewed each transcription while listening to the taped conversation. When reading the transcriptions, I began to write my responses to the conversation. Initially, I asked myself, "What is this person saying about her experience? How is she describing it? What does she talk about?" I began to write about each conversation in a journal. The journal served as a reservoir for my reactions to literary works, film, lectures, and as a medium for articulating questions relating to different aspects of the conversations. As my conversations with women and my exposure to all sources connected with this inquiry escalated, my journal writing became more focused on specific aspects of the topic. For example, when I read Wally Lamb's (1998) *I Know this Much is True*, I began to reflect on the issue of identity associated with monozygotic twins and to write about my reactions to particular chapters in the book. This writing generated more questions that, in turn, required me to read and write in a different direction. In this way, the research truly is in the writing. The writing that one does reflects the understanding that one has about the topic at any particular moment. Thus, the interpretations rendered in this work will never be

complete and final, as they can be challenged by and changed by something else that both writer and reader encounter in the world.

How did I know when to stop "in the spinning out of implications of meaning" (Jardine, 1992, p. 59)? As Jardine (1992) says, there are widespread possibilities of meaning in any particular incident. My interpretations of meaning are based on how I, with my own pre-understandings, prejudices, and history, search for, find, read, and write about the particular incident that I am addressing and how that particularity fits into the world. This does not mean that I did not systematically search for sources about twins, twin pregnancy, and mothering.[4] Instead of approaching what I found as a "simple accumulation of new objective information" and then 'telling' this information to the reader, I attempted, through my own transformations in understanding, my written interpretations, to "evoke in the reader a new way of understanding themselves and the life they are living" (Jardine, 1992, p. 60).

Evaluating

Objective measures of scientific reliability and validity are not appropriate for works with experiential, esthetic, and artful intent (Eisner, 1981; Jardine, 1992; Sandelowski, 1991; 1994; Van Manen, 1990). Scholars suggest that, rather than attempting to determine the reliability and validity of an interpretive inquiry, one evaluates such an inquiry on the basis of its intent, and of its adherence to the basic

[4] Databases for nursing, medical and ethical literature were accessed to 1999. A manual search of the Cumulative Index to Nursing and Allied Health Literature, 1975-1982, was completed. Terms searched were: pregnancy, twins, multiple pregnancy, multiple gestation, mothering, multiples, parent-child relations, mother-child relations, reproductive technology, in vitro fertilization, vanishing twin. Similar terms were searched in the psychological and educational database, as well as the term, double.

underlying philosophy of the tradition in which the inquiry was conducted.

In an interpretive inquiry such as this, the researcher is preoccupied with "how experience is endowed with meaning" (Sandelowski, 1991, p. 165), rather than how to know truth. Ken Wilber (1996) suggests that interpretive inquiry is concerned with putting forth a "subjective truthfulness" in writing, because interpretation of an experience is subjectively verbalized and cannot be visually validated using a correspondence theory of truth (p. 108). He maintains that experiences, which are located in the inner consciousness of an individual, can only be accessed with communication and interpretation, and therefore any empirical claims to validation of experience are not appropriate. Truthfulness can be found in the sincerity, honesty, and trustworthiness of an intersubjective exchange in a particular context which results in mutual understanding about some subject. Mutual understanding is not present if subjective truthfulness is not present. Therefore, the presence of understanding in the researcher's exchanges with women participants indicates a measure of truthfulness in her interpretation.

A good interpretation is rendered with the philosophical tenets of hermeneutic-phenomenology as its base. Thus, a good interpretation:

- "is not definitive and final, but is one that keeps open the possibility and the responsibility of *returning,* for *the very next instance* might demand of us that we understand anew" (Jardine, 1992, p. 57).
- is "unavoidably linked to *me"* yet "what the interpretation is henceforth *about* is not me and my past experiences, but that *of which* I have had certain experiences"

(Jardine, 1992, p. 58), and thus it is that the topic is the centre of this work, not the researcher's own experience, yet by the very nature of the question and of the researcher's involvement in the conversations and in the interpretation, the researcher is inextricably linked with the research.

- recognizes that all understanding involves some "legitimate" prejudices, as the researcher cannot be divorced from her own history, traditions, or present place in the world (Gadamer, 1982, p. 246). "The important thing is to be aware of one's own bias, so that the text may present itself in all its newness and thus be able to assert its own truth against one's own fore-meanings" (Gadamer, 1982, p. 239). The researcher comes to the research with prejudices, presuppositions, and interests and these are not 'bracketed' or set aside, but become important to the interpretation, allowing the researcher to question from a particular point of view. The researcher must be conscious of the presence of those prejudices.
- is one in which the researcher uses language to make it "possible to see what one is going through as intimately wound up in human life as a whole" (Jardine, 1992, p. 59).
- is one in which a sense of understanding is felt, and shared. "The proof for you is in the things I have made--how they look to your mind's eye, whether they satisfy your sense of style and craftsmanship, whether you believe them, and whether they appeal to your heart," says Margarete Sandelowski (1994), when speaking of the validity of qualitative research findings.

A good interpretation is not generalizable in the way of the natural sciences. In

interpretive work, one does not make inferences from sample to population based on a set of strict requirements. Yet I cannot say that a form of generalization is not possible as a result of transforming understanding about a topic. Interpretation, through focusing on the particularity of experience within the human world, and because of "long-standing characteristics of human experience and articulation" (Jardine, 1992, p. 58), attempts "to shed light on what is unique in time and space while at the same time conveying insights that exceed the limits of the situation" (Eisner, 1981, p. 7). Enlivening our understanding of a particular situation will make a contribution towards comprehending the general world, and thus may affect how we are in our very next encounter in that world.

Ethical Considerations

Ethical approval to conduct this inquiry was obtained from the Health Research Ethics Administration Board, University of Alberta (See Appendix F). Informed consent, confidentiality, anonymity, and an evaluation of the risks and benefits were ethical considerations discussed with each of the individuals prior to their participation in this inquiry.

All participants in this inquiry received information about the nature of the study prior to setting a time to meet with the researcher for an interview (see Appendix C and G). Consent was established with each woman prior to the initiation of an individual and/or a group interview (see Appendix H and I). Each participant in the individual and/or group interviews was informed of her right to withdraw from the study and her right to withdraw from the conversation if she wished to do so. Individual conversations were held at a location convenient for the participants. Most

often this was in the woman's home, but also included a hospital room, my home, a room in a university building, and at the workplace of one participant. The group interview was conducted in a room located in a university building.

When we convened for the group interview, several of the seven women participants knew each other from community contacts. When I realized this, I offered them the option to withdraw from the interview. I told them that whatever they said could be heard by the others in the room, and that I (and they) would have no control over where or how their words might be used outside of this room. None of the women participants chose to leave the group setting.

On many occasions our conversations were interspersed with laughter and with tears. On occasions when the participant became tearful, I offered to stop our discussion and asked if she wished to withdraw from the study. Instead of indicating that they wished to withdraw from the study, women responded with words such as: "No, I *want* to do this." On these occasions, we would stop talking. When the participant wished, we would continue our conversation. On several occasions, I spoke with the women about the kinds of support they had received after a child's death, or after a traumatic birth. I was concerned about feelings of anxiety that might surface as a result of talking about these experiences. All of the women indicated to me that they had received support following these events. Some had received professional counseling, some had attended support groups or church groups, and some said that their support had come from family. On all of these occasions, I offered to supply the names, locations, and telephone numbers of professional counselors if they felt they needed support after our conversation. All of these women

said that they did not need further referrals. This was a source of anxiety for *me*, something that *I* worried about. But at the same time I felt that our relationship within the inquiry was such that the women who had shared their difficult experiences with me would have told me if they had wanted further professional support.

Limitations

This inquiry is limited by my history—my social, cultural, and historical background—and by my own pre-understandings of the topic. It is also limited by my ability to interpret the experience of twin pregnancy from the conversations I have had, and from the other sources that I have used. Further limitations lie with my ability to write about the topic in a way that will evoke in others a new way of understanding the experience of twin pregnancy.

Chapter Four

Twinning

You are the ones who open doors on earth.
You are the ones who open doors in heaven . . . .
You, who are dual spirits.

Schwartz (1996), p. 23

Our fascination with twins has not dissipated over the centuries. Two fetuses sharing a womb, two infants sharing the birth event, two human beings often so alike as to be indistinguishable. Grist for the nature versus nurture mill (Schwartz 1996)! Cognitively, we seem able to acknowledge the outcome of a twin pregnancy to be two infants, but somehow the mystique surrounding twins remains. Faced with twins while pushing our grocery cart, in the church pews, or in the hallway of our child's school, we ask, "How does this happen?"

The path-ology of twinning

Identical or fraternal? This common question places twins into two categories: Those that look alike, and those that do not. We generally attach expectations to each category (Clegg &Woolett, 1988; Ingram, 1988). Look alike twins are the same sex, have the same timbre to their voices, are good at the same things, dress alike, strive for togetherness. Similarities are striking. We see double, the pair, but the pair before us is composed of one individual who has been duplicated, copied. They are two in number, each a copy of the other.

Twins who do not look alike, commonly called fraternal twins, are expected to look different from their twin, act differently, and generally are as different from each other as any siblings might be. We see before us a pair of girls, or a pair of boys, or a

boy/girl pair. The number of individuals is doubled, but the individuals are not duplicated. Their twin-ness is not declared to the world via their same-ness as it is with look-alike twins. We might think that these individuals look about the same age, or about the same size, and ask ourselves, "Could they be twins?" Unless we ask for confirmation of our observations, or they volunteer the information—"we're twins"—we can only speculate on this. Still, their very presence brings up questions: Are our expectations about twins linked to their number and their sameness? Do we expect different things from non-identical twins that we do from identical twins? Are non-identical twins a lower category, less exciting type of twin? What is it to be a twin?

Since technology has advanced our opportunities for prenatal ultrasound examination, zygosity testing, and DNA placental tissue testing, look-alike twins and twins who do not look alike have been reclassified as monozygotic and dizygotic respectively to better reflect their origins as 'one-egg twins' and 'two-egg twins' (Machin, 1997). The terms used to classify twins have taken us from those that indicate what we can see before us, as in identical, to words that indicate what the naked eye cannot see, that is, designation according to the number of microscopic zygotes present and their patterns of cell division.

Machin (1997) explains that monozygotic twins arise from a single egg (zygote) that goes through one extra mitotic cell division at varying intervals between conception and the laying down of the major body axes at about 14 days post conception. Monozygotic twins may share a placenta, an amnion, and a chorion during their gestation, or have separate amnionic and chorionic membrances.

Dizygotic twins develop from two separately fertilized zygotes, and do not share amnions or chorions while in utero. These twins may have separate placentas or their placentas may fuse together during pregnancy, appearing at birth to be a single placenta (Clegg & Woolett, 1988; Machin, 1997; Rothbart, 1994). Dizygotic twins may be fathered by the same person, or each twin may have a different father.

A third type of twins are conjoined twins, historically referred to as 'Siamese' twins. From the pathologist's point of view, conjoined twins are a result of incomplete splitting at the cellular level where one body axes has been formed, and then another axes is attempted (Machin, 1997). This cellular phenomenon results in twins that are physically joined, perhaps at the abdomen, or chest, or head.

In the vanishing twin syndrome, one of the two gestational sacs in the uterus indicating that twins have formed disappears in early pregnancy. With the advent of prenatal ultrasound examination as a routine diagnostic tool, one can be diagnosed with twins early in pregnancy. Later, another ultrasound examination can reveal a singleton pregnancy—one of the twins has vanished (Landy, Keith, & Keith, 1982; Yoshida & Soma, 1986).

Incidence of twinning

Attributed to advancing reproductive technologies, an older maternal population at conception, and improved perinatal outcomes, the incidence of multiple pregnancy is increasing on an international scale (Botting, Macfarlane, Daw, & Bower, 1989; Hay, Gleeson, Davies, Lordern, Mitchell, & Paton, 1990; Malmstrom & Biale, 1990; Miller, Wadhera, & Nimrod, 1992). Twin pregnancies may be

spontaneously conceived or be conceived as a result of assisted reproduction. Historically, the prevalence of spontaneously conceived monozygotic twins has remained constant worldwide with respect to age, race, or use of ovulation-induction medications. Recently, the incidence of monozygotic twinning has increased, as a result of assisted reproductive technology (Bowers, 1998; Machin, 1997). Such assistance may come in the form of ovulation induction with fertility drugs, artificial insemination, in vitro fertilization, gamete intrafallopian transfer and related technological procedures (Bowers, 1998; Manzur, Frederick, Goldsman, Balmaceda, Stone, & Asch, 1995). With the advent of selective reduction techniques, many higher order multiple pregnancies (i.e. triplets, quadruplets, and more) are reduced in number, and thus become a twin pregnancy. Approximately 10% of monozygotic twins result from assisted reproduction (Machin, 1997).

Overall, in Caucasian populations, 30% to 40% of spontaneously conceived twins are monozygotic and 60% to 70% are dizygotic. The incidence of dizygotic twins varies with ethnic and geographical differences (personal communication, Dr. G. Machin, October 8, 1998).

One can expect a higher incidence of multiple births in women who have delayed childbirth into their late 30s; already have several children; already have dizygotic twins; are multiples themselves or who have a family history of multiples; belong to a race who appears to have a genetic predisposition to dizygotic twins (ie. Nigerian women have the highest incidence of dizygotic twinning, whereas Japanese women have the lowest); become pregnant soon after discontinuing oral contraceptives; have taken fertility drugs; have undergone assisted reproductive

technologies; have a high level of education (Bowers, 1998; Jewel, 1995; MacGillivray, Samphier, & Little, 1988; Machin, 1997; Rothbart, 1994).

In Canada, twin births are reported nationally and provincially in three categories based on the result of the births, that is whether both are born alive, one is born alive and one is stillborn, or both are stillborn (Miller et al., 1992; Statistics Canada, 1996). Regardless whether both infants are born alive or both stillborn, the number of birth occurrences is recorded as one. Statistically then, the birth of twins is considered as one birth rather than the birth of two separate individuals, requiring two individual birthing events. A mother may birth her first twin, gaze at the baby, touch and cuddle her child, and then reluctantly surrender her to a health care professional to concentrate on the birthing of the other twin some minutes later. Yet this entire event is categorized as a single 'twin' birth. The birth of two individuals becomes lost in the recording of one event. The birthing of 'two-in', twins, becomes a record of one. Two are reduced to one.

Twin Mothering and Nursing Research

Relatively little research relating to twin pregnancy, twin birth, and the early mother-twin relationship could be found to assist me in my interpretion of womens' experience of twin pregnancy. Only 7 investigations using a variety of qualitative methods to study the mothering of twins could be found in the literature (see Appendix J). The reported research encompasses the time period from 1977 to 1995, utilizes a number of data collection techniques, and addresses various specific aspects of the mothering experience, such as stressors, caregiving, role changes, relating, and maternal adaptation (Anderson & Anderson, 1987; 1990; Broadbent, 1986;

Dickerson, 1981; Frazer, 1977; Goshen-Gottstein, 1980; Leonard, 1981; Van der Zalm, 1994; 1995).

Similarly, little research from the quantitative perspective relating to the mothering of twins could be found in the literature (see Appendix J). The reported research encompasses the time period from 1982 to 1997, utilizes a number of designs and data collection techniques, and again addresses various aspects of the mothering of twins, such as bonding, abuse, self-diagnosis of pregnancy, patterns of womens' experience, maternal factors during pregnancy, physical and emotional well-being, and assisted conception (Abbink, Dorsel, Meyners, & Walker, 1982; Agustsson, Giersson, & Mires, 1997; Malmstrom & Malmstrom, 1988; Olivennes, Fanchin, Kadhel, Fernandez, Rufat, & Frydman, 1996; Robarge, Reynolds, & Groothuis, 1982; Rydhstrom, 1990; Thorpe, Greenwood, & Goodenough, 1995; Woolett & Clegg, 1989). Each of the investigations extended the available knowledge regarding the mothering of twins, and provided new insights into selected aspects of the mothering experience. Yet, none of these researchers addressed what it is like for women to experience a twin pregnancy, nor do they address possible meanings that women attribute to these unique mothering experiences.

Chapter Five

What is a twin?

"It's not just a pregnancy, you know—it's twins!!"

When women find out they are expecting more than one child, the news to husbands, partners, family, and friends, includes exclamations of "it's twins". The word 'twin' says something special about this pregnancy. It has become not just 'pregnancy', or 'a' pregnancy, but a *twin* pregnancy. What are the origins of that significance? What is the significance of 'twin'? To answer these questions, I looked at treatments of the 'twin' in mythology and legends, in historical and literary sources, and in film. It is these sources that have influenced our current beliefs about the 'twin'. It is within these that I sought out the "family resemblances" and "analogical kinships" of meaning, of which Jardine (1990) speaks (p. 227). Through these nuances and associations I could begin to seek an answer to the question: What is a twin? In this chapter, I outline the myths, literary works, and films that have influenced my understanding of what a twin is, here, in my culture, and in my place in historical time.

Twins are Myth and Legend

I looked first to mythology, the depository for those things about the human condition that people find important. Cavendish (1980) says that myths express beliefs, mold behavior and justify institutions, customs and values. They cast light "not only on other people's minds but on our own" (p. 11), because the places of myth are the places in which our own history begins.

Romulus and Remus

> A Vestal Virgin names Rhea Silvia was raped and named the rapist as the god Mars. She gave birth to twin boys, Romulus and Remus. The twins were exposed to die in a basket on the river Tiber, but the basket was washed up on the bank at a place where a fig tree grew, near a cave called the Lupercal, the Place of the Wolf. A she-wolf found the babies and suckled them, and they were eventually rescued by a shepherd named Faustulus, who took them to his wife, Acca Larentia, to care for. When the boys grew up, they founded a new city, which was to become Rome, at the place where they had been saved from death as babies. They quarrelled, however, and Romulus murdered Remus. Romulus fortified the Palatine Hill, sacrificed to the gods and gave the people laws. (Cavendish, 1980, p. 139-140)

As twins, brothers, and strong survivors, Romulus and Remus overcome tremendous odds to become leaders and found the city of Rome. With two strands of parentage, the animal and the human, the twins are outside the natural order of things. Suckled and reared by a savage beast, they are objects of awe and set apart from the rest of men. They are deserving of the loyalty of mere mortals. Yet they succumb to the frailties of other humans, the dark emotion of anger, the desire for revenge, and then death. The stronger twin survives the weaker twin. Romulus *and* Remus becomes *jus*t Romulus by the act of death.

Castor and Pollux

So alike they were, no mortal

Might one from other know:

White as snow their armour was:

Their steeds were white as snow. (Macaulay, cited in Guerber, 1993, p.244)

Sons of Zeus, mortal Castor and semi-divine Pollux are Roman heroes, renowned for their athletic ability, protectors of the sacred city of Rome, young, strong, and beautiful. A dispute over women led to bloodshed and Castor was slain. Pollux begged to share his brother's fate, and refused immortality if he could not share it with Castor. To comfort his son, Zeus allowed him to share immortality with Castor, staying with him in the heavens. There, they form Gemini, a constellation of two stars—Castor and Pollux—the heavenly twins. One star of Gemini rises as the other sets—the twins take turns living one day on earth and the next among the gods of Olympus (Abbe & Gill, 1980; Cavendish, 1980; Guerber, 1993; Grimal, 1972; Schwartz, 1996). As gods and as stars, Castor and Pollux are outside of the natural order of things, super-natural. As children of the king of the gods, they are 'divine twins', but as twins they are 'divine', not of this world. The constellation Gemini dominates the sky from late May to late June, and those individuals born at this time are said to have dual characteristics.

The Dogon[5]

> In one placenta the male Nommo, called Yurugu, was impatient for birth. He could not wait for the period of gestation decreed by Amma, and forced his way out. He tore off a piece of his placenta and with it came hurtling down through space outside the egg. The fragment of placenta became the earth, but Yurugu's impatience had seriously disorganized Amma's plan for creation, for the earth was now provided with only a predominately male soul, and hence was incomplete, imperfect. From this situation arose the idea of impurity; earth and Yurugu were solitary and impure. Yurugu had been impatient to establish a domain over which he would rule, but he eventually realized that he could not do it without his twin soul. He clambered back to heaven to try to find the rest of his placenta with his twin in it, but he was too late. At his revolt Amma had handed over his twin soul to the other half of the placenta, and Yurugu could not find her. From that time he has vainly searched for her. He returned to the earth and began to procreate in his own placenta, that is with his mother, and from this horrible act there came into existence single, incomplete beings. (Cavendish, 1980, p. 226)

There is unity in duality. Twins are whole when they are connected, linked, together. One cannot exist without the other. A perfect existence is one in which the two are balanced, one with the other. A soul that is alone is incomplete.

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[5] The Dogon originate in West Africa. In Dogon mythology, Amma is the first personalized human being. Amma's sons, the Nommo, are twins, prefigurations of human beings, who took form in the cosmic egg. These formations, primordial events, took place in the egg, which was divided into twin placenta, each of which should have contained a pair of twin Nommo (Cavendish, 1980).

Cosmas and Damian

> In the year AD 292, when religious persecution under the Roman Emperor Diocletian was raging, Cosmas and Damian[6] happened to visit the city of Lycia, where the anti-Christian Covernor Lysias of Cilicia apprehended and attempted to kill them. He threw them first into the sea, then into a furnace and, when these efforts failed, he tried to crucify them. While they were hanging on the crosses, a mob tried to stone them, but the stones recoiled to their own heads. In addition, the arrows of archers ordered to shoot at Cosmas and Damian boomeranged in the air and returned, scattering the bowmen. Finally, in 303, Lysias had the twins beheaded. Their bodies were carried into Syria, and buried at Cyrrhus, the chief center of their cult, but even their death did not stop their work. Many miracles of healing were said to have occurred at their hand after their death. Sometimes they would appear to sufferers in their sleep, prescribing treatment or immediately curing them. (Abbe & Gill, 1980, p. 23)

Twins are magical beings, supernatural beings. They are capable of powerful acts.

Twins are Monsters

> Twins there are who will not vanish, whose flesh is your flesh, whose death is your death. Such intemperate infinity appears wherever a pair seem to

[6] Abbe and Gill (1980) speak of Cosmas and Damian as the most celebrated patrons of medicine and pharmacy in the Christian countries. Cosmas, the physician, and Damian, the apothecary, were known for their medical successes and their devotion to Chrisitanity.

themselves "as nearly as possible, one being in two bodies". (Schwartz, 1996, p. 49)

Imagine the fear, awe, and uneasiness that a pregnancy yielding two infants would evoke in the superstitious mind of a medieval peasant. No technological procedures to 'diagnose' a pregnancy that is different from others one has experienced or witnessed. No scientific knowledge on which to base an intellectual discussion of zygotes and cellular division, and their relationship to this birth. Just a pregnancy that might seem to be the same as the last, until the birth of two infants, often infants that look exactly alike. This birth is viewed as an omen. Of what? Will the crops fail? Will there be a flood or some similar natural disaster? Are there evil spirits or evil bodily humors surrounding or within these infants?

Now imagine yourself present at the same birth. Only this time, instead of the woman's labor yielding two separate infants, conjoined twins are born. Inseparable twins, joined at the chest, or at the back, or at the abdomen, or maybe at the head. Something you have never seen before--an object of fear, of fascination. What is it? Is it one body with two heads? Is it two bodies with one head? Trying to make sense out of what we see, we can only exclaim, "It's a monster!"

Conjoined twins have a long history as monsters, says Schwartz (1996). Monster, from the Latin *monstrum*, means divine portent. A birth of a monster is a powerful message from the gods, or from God, one of ominous significance.

As unexpected events, monsters had been unnatural and "frightening" and were put to death; as peculiar things, they were preternatural and "strange" and were displayed alive for a few sous, then sold at death to dissecting

> theaters; as novel beings, they were "anomalous" and were fitted to their own classes, orders, genera, then preserved in large glass jars. (Schwartz, 1996, p. 50)

The riddles in the birth of conjoined twins seem obvious: Are they two separate beings, separate souls, or are they one? How could they be physically indivisible yet individual? Perhaps they are something that we could not categorize? Something between the one and the two? An *in-distinct* self?

Conjoined twins, have been called 'Siamese' twins since the nineteenth century because of the notoriety of Chang-Eng, who were also known as Chang and Eng. Joined at the chest, Chang-Eng toured the US and Britain as the 'Siamese Double Boys', scrutinized by physicians, anatomists, phrenologists, and of course, the public. They lived their life (lives) joined. They married sisters and fathered a total of twenty-one children (Hunter, 1964; Wallace & Wallace, 1978). The public demanded that they be separated, "for the sake of personal liberty and the intelligent pursuit of happiness" (Schwartz, 1996, p. 54). Experiments were devised to determine if they were one mind in one body, or two minds in one body.[7] As they aged, their tastes and interests diverged, yet the band of flesh that joined them became less elastic. Physically, they became closer. Later in life, the stooped Chang had to lean against an aging Eng. They looked for a way to be separated, but American and European surgeons felt they could not safely conclude the surgery. Chang had a stroke which

[7] The experiment: "an experimenter had aides whisper the same questions separately to Change and to Eng, from whom were received enough discrepant replies to conclude that Chang had the greater energy and will, Eng the greater powers of reflection" (Schwartz, 1996, p. 55).

paralyzed his body. After this, Eng had to drag his brother from place to place. One of Chang-Eng's neighbors wrote of their death in 1874,

> "Chang dying first from pulmonary pneumonia contracted by his intemperance and imprudent exposure . . . Eng his brother died in two hours after from fear and the sudden shock he received on awakening and finding his brother, instead of a breathing living soul, a cold and chilly corpse by his side . . . . the great shock and terror inspired by such a union with death, added to which was the belief which prevailed between them that when one died the other would." (Schwartz, 1996, p. 57)

Chang and Eng were autopsied, embalmed, and cast in plaster, and can be viewed in a glass case at the Mutter Museum of the College of Physicians in Philadelphia. Schwartz (1996) tells us of the living contradiction that was Chang-Eng:

> During an aggressive period of industrial capitalism, projected under the flags of national competition within an economic universe gusseted by telegraph cables and railroad ties, the Siamese Twins were at once a blatant anachronism (of village mutuality) and a close-fetched utopia (of union brotherhood, socialist cooperatives). They were indivisible but individual, and at the end, as they drew physically in upon one another, they grew emotionally apart. What happened to them was happening to the world beyond, which, as it shrank with quick news, seemed to be plagued with fits of (economic) depression, shortness of (political) temper, bursts of (military) anger. The Siamese Twins were no more monsters than other men and women of the

nineteenth century who found themselves caught up in subtle, possibly fatal bonds. (p. 58)

Being a 'Siamese' twin is being joined together at some bodily point, each twin using the same or some of the same internal bodily organs and functions. To us, they seem to share a body. Without this sharing, the twins could not survive. They can only survive as one, not as two. We recognize that their bodily sharing necessitates the sharing of other experiences—where one goes the other goes. To share is to portion, to divide equally. In saying they 'share' their body, is it our way of trying to make sense out of something that is difficult to comprehend? Do they instead exist as a whole, where one and one do not make two, but instead form a 'whole' that we cannot recognize because our comprehension of wholeness lies in the 'distinctness' and 'separateness' of human beings? And so any notion of sharing must mean a division, a portioning. Because conjoined twins are not 'separate', then they must 'share'. We categorize their unique form of wholeness into sharing. And the mystique surrounding their sharing becomes a horror, a sideshow, rather then simply a mystery.

Do the people that are 'Siamese' twins exist within the same body as two people, or as one? Are they like Rahel and Estha, two-egg twins with a "Siamese soul" (Roy, 1997, p. 40)? They "thought of themselves together as ME and separately, individually, as WE or US. As though they were a rare breed of Siamese twins, physically separate, but with joint identities" (p. 4). Perhaps the term conjoin, from *conjoigne*, to link, to join together, to unite, to combine, refers not only to a bodily joining but also to a uniting of person that goes beyond the mere assigning of a

label—you are twin A and you are twin B, or together you are A-B, as with Chang-Eng. Perhaps these twins are *more than* in their joining, instead of *less than*.

Twins are a Comedy of Errors

> There had she not been long but she became
>
> A joyful mother of two goodly sons,
>
> And, which was strange, the one so like the other
>
> As could not be distinguished but by names. (Shakespeare, 1996, Act I, Scene 1, 49-52)

Mistaking one twin for the other, an error that can become a comedy, is a dramatic theme that has reoccurred in theatre since Plautus' *Menaechmi* (Gedda, 1961). In Shakespeare's (1996) *The Comedy of Errors,* two pairs of identical twins are born on the same day in the same household—one set of twins becomes the servants of the other. Each set shares a single name. During an ocean voyage, they are all shipwrecked and reach safety but in different locations. One master and one slave become separated from the other pair.

Years later, Egeon, the father of the twins, his son Antipholus, and the servant Dromio, begin to search for Egeon's lost wife and son. As a foreigner from Syracuse, Egeon is imprisoned in Ephesus. Antipholus and Dromio take lodgings in Ephesus. One or the other of them is confronted by another Antipholus and Dromio, but because the sets of twins are so alike, errors of mistaken identity begin. Master and servant mistake the identity of the other. Wife, sister-in-law, and fiancé, compound the error of mistaken identity. No one understands that it is their interpretation of the physical resemblances of the twins and the assumptions that they make as a result that

are the source of the 'errors' that are made, rather than the 'errors' lying with the twins themselves. It is the twins who are thought to be mad, not those who continually mistake one for the other. At the end of the play, when the twins are seen together, the errors of mistaking their identities begin to be explained. Yet, even with explanations, twins remain unusual—one must be real and the other supernatural, not of this world:

> One of these men is genius to the other.
> And so, of these which is the natural man
> And which is the spirit? Who deciphers them? (Shakespeare, 1996, Act V, Scene 1, 343-345)

Twins are Uni-form

> "Oh, look, Martha! Over there—identical twins! Are you their mother? How in the world can you tell which is which?"... You know what that was like, growing up? Having that be your big claim to fame? Hearing your whole life that you were . . . *interchangeable* or something? (Lamb, 1998, p. 604)

To be a look-alike twin is to exist in uni-form. Not to don identical outer apparel to appear to be more alike, or to be in a military uniform or a team uniform, but to *exist* as one form. With this identical uni-form, twins become duplicates. To be a duplicate is to consist of, or exist in, two identical parts; to correspond in all respects to something else. To be a duplicate is to be interchangeable with another, to substitute or serve in the place of another. When one is of uni-form with another, we make assumptions about the individuality of each. One becomes the other.

In Dumas' (1998) tale the *Man in the Iron Mask*, Louis and Phillipe are identical twin brothers born as princes of France, sons of King Louis XIII. The birth of twins to a French monarch was not cause for joy, but for "terror" as doctors and jurists could not distinguish which child was the elder—"there is ground for doubting whether he who first makes his appearance is the elder by the law of Heaven and of nature" (p. 21). Under French law of the time, the right of succession of twins to the throne was thought to be equal, "twins are one person in two bodies" (p. 212), so both sons should succeed to the throne and reign as kings together. Louis XIII "apprehended a series of conflicts between two children whose rights were equal; so he put out of the way—he suppressed—one of the twins" (p. 211). Phillipe was confined in the Bastille, an impenetrable prison, for eight years until a plot by musketeers (the imperial guards of the French monarchy) substituted Phillipe for Louis. Phillipe's kingship lay in his uni-formity, his ability to be substituted for Louis, rather than in his individuality. He looked like Louis, therefore he *was* Louis. Who would question the king? The musketeers hoped that the results of the plot would be successful, that is, Phillippe would employ the qualities of a 'good' king--honor, nobility, courage, thoughtfulness—qualities that his brother appeared to lack.

In the film version of this story, Phillippe assumed Louis' identity and reigned successfully as King of France until his death many years later. In Dumas' (1998) original version, Phillippe's deception was quickly discovered and he was placed in exile with a mask of iron covering his face and head, while Louis resumed his place as sole King of France.

When loyal subjects discovered Phillippe's deception and freed Louis, Louis did not have Phillippe murdered but covered his face. Louis and Phillipe were no longer uni-form. By eliminating Phillipe's uniformity with Louis, Phillipe was rendered without influence. When Phillippe's face was eliminated, his identity was eliminated. He became just another political prisoner of France. Is our identity in our face, in the features we present to the world? When we see two faces the same do we think that the identity of the persons behind what we see is the same? To have an identity is to retain a core of sameness under varying conditions, to be oneself and not another. If twins have the same face, do they have no identity of their own? Are they merely 'the twins', separately incomplete? As linked by their facial sameness as Chang and Eng's chest band of flesh? Two becomes one.

Twins are Connected

> But I knew Thomas was dead. Had felt his dead weight since I'd swung my legs out of bed after that phone call. It was like I was dragging around some dead part of myself . . . . If your twin was dead, were you still a twin? (Lamb, 1998, p. 711, 751)

Wally Lamb's (1998) *I Know this Much is True*, is about Dominic and Thomas, identical twin brothers. Born on December 31, 1949, at 2357 hours and on January 1, 1950 at 0003 hours, they are twins who do not share a birthday, a year of birth, or even a decade of birth. They share an outward appearance, and as boys, they experience life together, attending the same school, working in the same school grade, playing with the same friends. From boyhood, Dominic struggles to be *just* Dominic

instead of *one of the twins.* He feels bound to, tied to, connected to Thomas by their twin-ness in ways that are negative—he is never alone to be just himself.

It is Thomas' slow descent into mental illness, and his eventual diagnosis as a paranoid schizophrenic that allows others to differentiate which brother is which. Thomas is the twin who is ill, Dominic is the twin that is not. To Dominic the illness is a genetic contradiction. Dominic struggles with the realization that monozygotic twins are genetically identical, yet Thomas is the one who is ill: "Why did it tag him and not me? His identical twin. His other half. That's what I've never been able to figure out. Why Thomas was 'it', not me" (Lamb, 1998, p. 320).

Schizophrenia is *schizo*, from the Greek *schizein*, to split, to part, and *phrenia*, mental disorder. Thomas' illness splits the twins physically, as they no longer look exactly alike--Thomas gaunt, disheveled, and tobacco stained, while Dominic lifts weights and plays squash to stay fit. And it separates them cognitively as Thomas becomes more and more absorbed with the Bible and those forces that are trying to destroy him. Yet Thomas' illness brings the twins together in a new way, as Dominic fights for his brother's rights, cares for him, visits him, becomes his protector. To protect Thomas is to protect himself. To care for Thomas is to care for himself.

> Mostly I can just accept it you know? That total absorption of his—the way his illness finally did what I'd been trying all my life to do: separate the two of us. Untwin us. But I'll be honest with you. There have been times when I've ached to have him back again. When I've needed him bad. (Lamb, 1998, p. 320)

Dominic is not physically connected to Thomas in the literal sense like Chang-Eng was physically connected, but the push-pull of a felt connection, a bond that cannot be severed, is there for him.

> You want to know what it's like for me? *Do you?* It's like . . . it's like . . . my brother has been an anchor on me my whole life. Pulling me down. Even before he got sick. Even *before* he goes and *loses it* in front of . . . An *anchor!* . . . That he's my *curse*. My *anchor*. That I'm just going to tread water for the rest of my whole life. That he is my whole life! (Lamb, 1998, p. 280)

Dominic's anchor makes it difficult for him to move ahead with his own life, but his anchor also keeps him from straying into dangerous waters, shoals, perils. Being anchored steadies him and keeps him safe.

To be connected to the other is to be linked, to be bound or fastened *with* something. Twins can be connected in the most obvious of ways. Conjoined twins are bound together physically. Monozygotic twins are linked by their physical likeness. These connections immediately come to mind. Are there other connections that twins have that are less obvious to us? What of their pre-birth connections in the womb where they cannot readily be seen? They are together in an enclosed space from the first moments of perception. Sharing? Competing? The movements of one into the other. Touching each other with hands and bodies. Kicking each other. Lying on top of each other. Sleeping together. In some cases, commingling their blood. What kind of connections are forged in the womb *before* those connections are altered, severed, by their introduction to the outside world? Where their connections become what can be seen by others, their physical likeness or physical joining? We can only speculate.

In death, one could say that any bond between twins is severed. Yet even with Dominic's life struggles to differentiate himself from Thomas as the normal twin, the healthy twin, and as *just Dominic*, he also struggles in death with being *no longer twinned*:

> It's like . . . it's like losing a part of who you are. I don't know. In a lot of ways, we were pretty different. Which was fine with me. Just the way I wanted it. But all my life, I've been . . . I've been *half* of something, you know? Something special—something kind of unique—even with all the complications. *Wow, look. Twins* . . . . And now, that specialness—that wholeness—it just doesn't exist anymore. So it's weird. Takes some getting used to . . . . Not that it was ever easy: being his brother. Even before he got sick. (Lamb, 1998, p. 818)

Twins are Doubles

> Her twin was her best friend, and the other side of her own soul . . . . They were made of one cloth, like two dresses made of one bolt of fabric, with no seams, no tears, no differences. There was no place where one began and the other stopped. (Steel, 1998, p. 36, 419)

To be a twin is to be double. In the mathematical sense, to double is to be twofold in size, form, amount, number, extent. So, one becomes two.

In the literary sense, the twin as double is the second self, the incomplete self, the divided or reflected self, the shadow self, the *doppelganger* (Hallam, 1981; Miller, 1985; Schwartz, 1996). The twin as double is the escaped inner soul of an

individual, living without.[8] "Uncanny . . . strange . . . dreadful . . . a split figure" (Hallam, 1981, p. 14), the double has evolved from a complimentary guardian angel character to depictions as malevolent, an announcer of doom, a controller of the other, a part of a fragmented whole. Polarities become obvious in the struggle between the self as good and the shadow self as evil. Images appear: the good twin versus the evil twin; the light versus the dark. The phenomena of the "syzygy" (split figure) becomes constructed as a psychological disorder (Hallam, 1981, p.15; Schwartz, 1996), a categorization to help us recognize and remember that one individual has only one face and one body.

Elliot and Beverly Mantle,[9] fertility gynaecologists in the film *Dead Ringers* are literally 'dead ringers' for each other—they are identical twins. At the instigation of the dominant twin, Elliot, they switch places with each other in their office practice, in the operating room, at formal functions, with women. "No one can tell us apart. We are perceived as one person," Elliot tells his girl friend. Neither sees anything wrong with switching identities.

Bev utilizes his skill as a practitioner and surgeon to help women to become pregnant, and he designs projects and collects data for their infertility research program. Elliot dislikes practice and the detail of research, but loves the political

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[8] Sir James Frazer (1960) has written about the historical aspect of the portable soul. "If a man moves or lives, it can only be because he has a little man or animal inside who moves him. The animal inside the animal, the man inside the man, is the soul . . . . Hence if death be the permanent absence of the soul, the way to safeguard against it is either to prevent the soul from leaving the body, or, if it does depart, to ensure that it shall return" (p. 207). People adopted rules and taboos, and took elaborate precautions to ensure the continued presence or return of the soul to the body.

[9] A mantle is something that covers, or conceals. Perhaps a double conceals rather than reveals.

aspects associated with their work—attending dinners, making speeches, collecting awards. With each brother utilizing the strong points of the other, and pursuing their own interest, they become more and more successful. In their impersonations of each other, they become complete—they are *more* when they assume the identities of self and other than they are as individuals. "The only impersonation I ever did was my brother," says Beverly when defending their practice to his girl friend.

As Beverly seeks to have a life away from his brother, he has nightmares of being separated from his brother. He begins to abuse drugs, and he becomes more confused about who he is. "I'm one of the Mantle twins," he introduces himself. His drug problem worsens and he tries to do surgery under the influence of drugs. After being exposed as an incompetent practitioner because of his drug problem, Elliot puts Beverly on a detoxification program, but Beverly does not follow it. To cope with his brother's addiction, Elliot begins to take uppers so he can stay awake and watch Beverly. Elliott continues to take drugs, his behavior becoming indistinguishable from his brother. "Bev and I just have to get synchronized. Once we get synchronized then it will be easy," he says. Oral drugs are mixed with intravenous drugs and alcohol, and Bev prepares Elliot to be separated. "We are about to separate the Siamese twins," he announces. He gives Elliot drugs and takes drugs himself. To 'separate' himself from his brother, he opens Elliot's abdomen, and as a result his brother dies. Bev tries to go to his girl friend, but instead he returns to his dead brother and then kills himself.

Twins are Scientific Controls

It's a good bet that gambling may be in your blood after all

Twin genes

> Because it involved a large federal database of 3,359 sets of twins—identical and fraternal—who served in the military during the Vietnam War, the study provides strong evidence genetics plays an important role [in gambling]. Researchers found that when one twin had a gambling problem, the other was far more likely to have a similar problem. The effect was greater in fraternal twins, who share about half their genes, than it would have been for two people picked at random from the general population. And for identical twins, who have the same genetic code, it was greater still. (National Post, November 26, 1998, B5)

Sir Francis Galton originated the 'classic twin method' as a scientific experiment. With his belief in hereditary genius, rather than "cultural advantage", Galton believed in "genetic gardening of the human population"—populating the world with talented and hardy strains of individuals and weeding out the defectives (Wright, 1997, p. 14).

Although the pathology of twinning was poorly understood at the time, Galton postulated that the comparison of look-alike twins would give clues as to which human characteristics were genetic and which were shaped environmentally. In 1875, Galton wrote of twins:

> Their history affords a means of distinguishing between the effects of tendencies received at birth, or those that were imposed by the circumstances

of their after lives; in other words, between the effects of nature and of nurture. (Wright, 1997, p. 12).

Studying twins could expose genetic secrets. From this belief, the eugenics movement was born. Over the years, scholars who believed in inherited talent, intellectual abilities, and temperaments warred with those who believed that these were imposed by society. In the hands of Nazi researchers in the 1930s and 1940s, eugenics and the study of traits in twins was taken to its evil extreme, the attempt at creating a super-race that would rule the world. Psychologists, physiologists, physicians, and other professionals continue to study twins. Wright (1997) describes the extensive Minnesota Experiment, where twins who were separated at birth are being studied separately, simultaneously, and in great depth:

> The twins usually arrive in Minnesota on a Saturday (international visitors arrive on Friday). They have been asked to bring whatever birth certificates, adoption papers, photographs, school and medical records, awards, and letters that they can find. Bouchard [principal investigator] usually greets them at the airport. Often the spouses or parents come as well, to be included in the family studies that have been added to the program. Sunday afternoon the twins go to Elliott Hall, where one twin begins writing out his life history, while the other twin in a separate room, takes the first of many personality assessments, which include the Minnesota Multiphasic personality Inventory, the Myers-Briggs Type Indicator, and the California Psychological Inventory. When they are finished, they switch places. Monday at eight, the first full day, the twins go to the hospital. Electrodes are attached to their scalps for

electrocardiograms; the twins also get a chest X-ray, a hearing test, and endure ninety-nine different physical measurements, including such things as arm size, head length, nose depth, ear shape, the diameter of the eyes. They occupy the rest of the morning by taking tests of mental abilities. After lunch, they have their fingerprints taken and their allergies tested, submit to a complete physical examination, they complete personality assessments until five-thirty. Tuesday, the longest day of the week, begins with a donation of blood before breakfast and again ninety minutes later, in order to measure the rate of insulin production. For the next twenty-four hours the twins wear monitors that record their pulse, blood pressure, and body temperature. They undergo lengthy psychiatric interviews and medical life histories. After dinner, the twins are faced with a sexual history questionnaire that is so intimate that many simply refuse to finish. Wednesday morning is full of visual and dental exams. Thursday, the twins are greeted with more mental abilities tests, voice sampling, psychomotor tasks to measure hand-eye coordination, and the Wechsler Adult Intelligence Scale. Each twin is videotaped lighting a cigarette if he smokes, catching a pair of keys that are tossed to him, drawing pictures of a hose and a person, writing a paragraph, and walking across the room and shaking Professor Bouchard's hand; the point is to make a visual record of their physical mannerisms. Friday features information-processing tasks, such as sorting objects into trays, and an interview that explores the major life stresses that each twin has experiences. The afternoon is occupied by a two-hour pulmonary exam and more tests of mental abilities and personality

assessments. Saturday concludes with a final round of mental abilities, information processing, psychomotor tasks, and personality inventories. (Wright, 1997, p. 48-50)

But in this research twins are the subjects, but not the topic. They are sought after as research participants because of their similar and often identical genetic codes, but twins often are not the topic of the research studies in which they are enrolled. Studies using twins as subjects often inform us about something else. The research questions refer to such topics as personality, IQ, language development, school grades, occupation choice, extra sensory perception, or religious attachment (Ainslie, 1985; Wright, 1997), and twins are used as "a suitable 'device' " for exploring these questions (Ainslie, 1985, p. ix). Why is this? Are twins, in their same-ness and yet their irregularity, thought to be objects that can be used to inform about something that has a greater importance than their own?

To be a subject in a scientific study is to allow oneself to be under the influence, the control, of an investigator. To control, from the French *contrerolle,* is to hold in check, to dominate, to command. An investigator controls variation in his experiment by using a parallel experiment as a standard for comparison (Christensen, 1991). To be a scientific control is to become the parallel, the object of comparison. But it is also to be controlled, to have one's personal qualities and characteristics become variables, observed and manipulated by another. To be designated a scientific control is to become not a whole individual but a research subject whose personal 'variables' are detached one by one from the whole so they can be studied piece by piece. And it is to lose control over how one is presented (or presents oneself) to the

world. As scientific controls, twins are linked to each other within the experiment by comparing variables. What is the IQ (or the language capabilities, or the cardiac output) of Twin A ? Twin B? The findings are polarized—who has more, who has less, are they different? Why or why not? In these polarities and comparisons, images of more—less, good—bad, even light—dark, emerge. Twins are connected biologically by the sameness of their genetic makeup, the similarities in what is innate, as much as they are connected by an investigator's recognition that those traits exist, and the comparison and assigning of value to those traits.

Twins are Copies

> I like the work well. I would have it copied. (Shakespeare, 1958, Act 3, Scene 4, 190)

Mathematically, twins are doubles. One becomes two. In the same sense of one becoming two, when a copy is made of something, it has become twofold. It has doubled. Yet, to copy, from the Latin *copia*, is to imitate or reproduce an original. Somehow a copy in its 'imitation' and 'reproduction' becomes less than double, less than the original. In its re-production, it becomes more the 'fake' than the 'real thing', a 'knock-off'. When making copies of an artwork, a legal document, or a book chapter, we are quick to point out: "*This* is the original; *that* is the copy." They may look the same and be reproduced in the same form, but we designate one as the original and the other as the copy. Original documents are cared for and filed differently than copies. Original sixteenth century artworks are cared for differently than twentieth century reproductions.

When faced with look-alike twins, with two individuals that look the same, could it be that a first born twin is the original individual, the original child, and a second born twin is a copy, a reproduction, a 'knock-off' child? Gromada (1981) says that women who birth twins that were undiagnosed during pregnancy may view the first born baby as the expected, wanted, and dreamed of child, and the second baby as an intruder. In womens' attempts to reconcile the actual event with the expected event, their twins are dressed alike, and treated alike. Somehow, in emphasizing their sameness, their number is decreased—they become less than two.

Twins are Clones

> clone: from the German klun, meaning a slip or twig; a group of organisms derived from a single individual by various types of asexual reproduction. (Webster's, 1989, p. 279)

When arrested for a crime, Steve, in Follett's (1996) *The Third Twin*, discovers that the crime was perpetrated by his 'double'. When he sets out to find his double, he finds a person he believes to be his identical twin. Only Steve and his double are part of a genetic experiment gone wrong. Instead of finding only one 'double', Steve finds seven men genetically identical to himself. They were clones:

> They picked a healthy, aggressive, intelligent, blond-haired man and woman and got them to donate the sperm and egg that went together to form the embryo. But what they were really interested in was the possibility of *duplicating* the perfect soldier once they had created him. The crucial part of the experiment was the multiple division of the embryo and the implanting into the host mothers. And it worked. (Follett, 1996, p. 354).

Clones are copies, but perfect copies. We expect clones to be absolutely identical in every way, to be flawless copies of each other, with no variation from one to the other. De Blois, Norris and O'Rourke (1994) call clones "artificial twins" (p. 211). Clones are artificial in their re-production. Artificial, from the Latin *artificialis*, means skilled workmanship. They are engineered through asexual reproductive technology, and thus the appearance of twins is expected, rather than a surprise during pregnancy. As products of a technological procedure, cloned twins become more a technological feat than a natural occurrence. Their mystique is somehow diffused, they become common, as our ability to engineer their existence becomes more sophisticated.

Twins are many things: Omens, monsters, supernatural beings, one person, two people, subjects that hold scientific secrets. To be a twin is to be complex, to be viewed with a mixture of awe and question, and sometimes to be feared. What is it like for a woman to carry twins in her womb? What is it like to wonder at one's own pregnancy, while at the same time, be the object of wonder? What is it like to be 'having twins'?

Chapter Six

The Gift

"They're a rare gift, I'm told."

When a woman desires a child of her own, her thoughts and actions are directed at conceiving—not at having twins. Even with a familial history of multiple birth, or the knowledge that a multiple birth may result from the use of assisted conception techniques, the conception of twins is not a woman's goal. When her pregnancy changes from *a* pregnancy to a *twin* pregnancy, she is given something that she did not seek to have. When a woman conceives twins, she is given "a rare gift".

Hyde (1983) says that a gift is "a thing we cannot get by our own efforts. We cannot buy it; we cannot acquire it by an act of will. It is bestowed on us" (p. ix). A gift is given to us: we receive. Giving and receiving are complementary and mutual. "There can be no act of giving without a concomitant act of receiving," says Zabielski (1984, p. 20). When a woman conceives twins, she receives the gift of another child. In being given and in receiving this gift, lies the opportunity for her to give her own gifts, those of her "innermost and completely involved self" (Rubin, 1967a, p. 203).

Receiving the Gift

In our modern times, women have their pregnancies confirmed by a technological procedure, a pregnancy test. From the result of the test, a woman *knows* that the changes she notices in her body are from a child growing in her womb. The pregnancy test result gives her that knowledge, a kind of knowledge that Hayne (1998) says is relevant to our particular historical period, a knowing *for sure* because an objective, scientific procedure has told us. Women have become pregnant and

birthed infants for thousands of years, but only recently have they relied on pregnancy tests to inform them that they are, *in fact*, pregnant.

Feeling different

Women are aware of bodily changes that occur from the time that they attempt to conceive a child to the time that they have conceived. They are also aware of nuances of bodily behavior as these appear in their pregnant selves. Sometimes, these subtle changes, taken together, give a woman a new knowledge about her pregnancy.

> Like I did the little home test, I knew I was pregnant and everything, and I kept telling him, "There's something different. It's not the same as before when I had the miscarriage and it wasn't the same when I was pregnant with Simon." I said, "There's something definitely, definitely wrong is the words I used. I said there's something wrong, there's something different."

Women have a bodily knowing during pregnancy that goes beyond objective scientific measurement (Patterson et al., 1986; Malmstrom & Malmstrom, 1988). They may know when their pregnancy is not the same as a previous one, or not the same as what they have read about, been told about, or watched occur to friends and family members. Their knowing is an articulation of their self as pregnant being. Yet, women still seek to communicate their knowing to one that they consider to have scientific knowledge, and to have it confirmed. In this seeking to confirm, have we become so trust-full of technology and what it tells us of the bits and pieces of our body (urine test=positive=pregnancy), the yes/no answer to our question, that we pass over or ignore the signs that our body is telling us? Or perhaps it is that we seek affirmation of our knowing, rather than confirmation? Once our knowing of our self is

affirmed, we can go on and complete the work involved in this pregnancy, feeling safer and more secure because we are not alone in this process.

To describe a pregnancy as "different", is to label it unusual, not ordinary, distinct, differing in character or quality than something. To associate "different" with "wrong", is to link the unusual with something going amiss. A woman attends to subtle signals in her bodily behavior that tells her that her pregnancy is out of the ordinary. "I know you get bigger earlier with subsequent pregnancies but this is nuts. I feel so much bigger, my breasts are so much bigger." "I would bend over the desks and this was at 6 or 7 weeks, and I would have to sit down beside a child's desk and I'd move the chair along down the rows. And I said this isn't me." "I felt heavy, I felt like there was a heaviness in my lower abdomen. That's the only way I can describe it."

Malmstrom and Malmstrom (1988) write that women who have experienced pregnancy before, as well as those who have not, are able to interpret their bodily behaviors and self-diagnose a twin pregnancy. Women attend particularly to an unusual increase in size or weight, and to dreams about a twin birth. Later, they are aware of more fetal movements than they expected, or specific separate fetal movements. The differentiation of single pregnancy from twin pregnancy is described as something that is exaggerated, something that is not normal.

> Some of the things that I noticed that were really different with this one was I was a lot more tired. You know I was just exhausted constantly, able to sleep all the time. You know just every symptom was exaggerated with me . . . . The fact that you're pregnant with two is almost like every pregnant issue that you

have to deal with in normal life is doubled . . . . And every symptom is exaggerated and multiplied.

To experience a normal pregnancy, is to experience that which is associated with the standard. In Western cultures, to have a standard pregnancy is to have a pregnancy without medical incident, to have one which conforms with the pregnancy norms that are published in the lay literature. Norms isolate womens' bodily behaviors and standardize them according to date, stage, gestational age, fetal development, size, weight gain, and symptomology, like Eisenberg, Murkoff, and Hathaway's (1996) *What to Expect When You Are Expecting*. Women base their expectations of pregnancy on these standards, and on experiences of friends and of family members. "For me a normal pregnancy just meant things were okay and, like I wouldn't notice any difference whatsoever." When their own experience deviates from what they feel is normal, when their own behavior seems to be "too much", or "not right", women speak of their pregnancy as different.

Finding out

These differences add up to something that often forms as a question in a woman's mind, a question that she brings to her health care professional at her next pre-natal visit. "Is everything okay?" she asks. Her question often culminates in another technological procedure, the prenatal ultrasound examination.

The technician turns on the monitor, then squeezes some cold jelly on the skin below my navel. She takes something that looks like a man's electric shaver and begins sliding it around on my belly. At first I think I'm going to lose control and pee all over the table. But a moment later I forget about my

bladder. There on the screen is a dark pod-shaped object undulating beneath the probe pressing against my belly. (Winer, 1994, p. 48)

During an ultrasound examination, the felt differences in a woman's pregnant self crystallize and are given form as a diagnosis.

> We went in there and the gal took a long time but I didn't know if she was new or what. I can remember her kind of smiling or grinning at certain things. I thought . . . I don't know what she was doing. I was kind of suspicious but I didn't really know. She went out to get the radiologist I guess and they called in my husband at the same time and the gal came in. She said everything looks really good. You are about 8 weeks or whatever it was at that point and you are having twins. I just remember thinking, oh my God, thank God I am lying down. I think I lost sensation everywhere when they told us.

Diagnosis, from the Greek *diagnostik*, means to be distinguished. Somehow, the diagnosis of just pregnancy that came before fails to capture the significance of her present situation. She, and her pregnancy, through the diagnosis, become distinguished, special, remarkable. Suddenly, her world has transformed. Not only is the pregnancy distinguished from what it was before this moment of diagnosis, but the mother is as well. By diagnosis she becomes 'high risk'. She is not just 'expecting', but 'expecting twins'. By diagnosis, a certain kind of status has been conferred. She, and her pregnancy, have become noticed, more defined, distinctive.

Seeing is believing

To experience a real-time prenatal ultrasound examination[10] is to be in a small darkened room, lying on a narrow slightly padded table, exposed belly offered to the ministrations of the whirring machinery and uniformed professional standing next to her. All concentration, all contemplation, all focus is on the grey, white, and black TV (or computer?) screen at the woman's eye level. She asks the technician to tilt the screen in her direction, so she can see what the technician sees. The technician hesitates slightly, then takes her hand off the 'controls' of the machinery, the buttons, and she complies. What does the pregnant woman see?

> There on the screen is a dark pod-shaped object undulating beneath the probe pressing against my belly. Attached along the pod's inner wall is a filmy gray amoebic mass, ghostly and primordial, swirling inward toward the center. At the tip of this mass floats a tiny dot of bright pulsing light. (Winer, 1994, p. 48)

She has difficulty associating this with what she knows to be growing, developing, and maturing in the safety of her belly. What does the technician see?

> 'There's the heartbeat,' says the technician. My husband is up now, leaning over me and staring at the monitor. The technician types out something on the keyboard and the letters B-A-B-Y appear on the monitor screen, with an arrow pointing to the swirling floating mass. (Winer, 1994, p. 48).

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[10] "In this technique, a transducer sends sound waves through the amniotic fluid so they bounce off fetal structures and are reflected back, either as a still image (scan) or, more frequently, a real-time moving image 'similar to that of a motion picture', as the American College of Obstetricians and Gynaecologists (ACOG) puts it" (Petchesky, 1987, p. 273).

A woman views an ultrasound image that is her unborn child. The child is alone, floating. It is hard to imagine where she, as woman and mother-to-be, fits into this picture. To most women without specialized training, the image is indistinct, amorphous. It is indeed a great leap of faith to believe that this "floating mass" is the child that a woman knows in a different way, living within her pregnant self. Through this image, her baby has become an "outside experience", out here in the room, rather than an "inside experience" within her body (Petchesky, 1987, p. 272).

She 'views' her baby. Somehow there is a distance imposed by the act of 'viewing'. We 'view' a house that we might wish to buy, or attend a 'viewing' of 'the body' after death. There is a one-sidedness, a lack of reciprocity in the viewing, almost a feeling of furtiveness at watching someone who does not know they are being watched. When we refer to this procedure as an examination, what are we examining? Do we examine the woman as pregnant woman, the woman's abdomen as home to the unborn child, or the future child?

The "ultrasound equipment is the intermediary between the physician and the pregnant woman", says Lumley (1990, p. 214) of the process of examination. Through this technological equipment, the physician and/or technician shows the child to the mother. They interpret their knowledge of her unborn baby to her, rather than she to them. Through their special skills, they help her to see her child as they are able to see it. In becoming the demonstrated-to rather than the demonstrator, the child becomes less hers. She loses sense of her pregnancy as *her* pregnancy. The information gleaned from the ultrasound, what Jordan (1987) calls privileged knowing, becomes her pregnancy. Her knowing of her unborn child is subordinate to

the privileged knowledge which is controlled by others, rather than something that she attends to in her self and passes on to others (Stewart, 1986). The attention to the fetus as main character in this drama of pregnancy "writes the woman out of the story" (Kaplan, 1994, p. 133). She becomes more "a container for the person of importance and of less importance herself" (Lumley, 1990, p. 217).

Ultrasound examination during pregnancy has become more the norm than the exception. The ultrasound image--the beating heart, and later the waving limbs and facial features—is viewed by health care professionals as an opportunity for an early maternal bonding experience analogous to quickening (Hyde, 1986; Reading, Campbell, Cox, & Sledmere, 1982; Stewart, 1986). Through ultrasound, one can present a woman with objective technological knowledge that there is a child in her belly, even if she has not yet sensed its first movements through the uterine wall. Of course, there is precision in this knowledge too, a precision about weight, length, head circumference, even gender, that a woman without ultrasound can only wonder at. Yet ultrasound, as a form of technological quickening, cannot take the place of womens' experience of quickening. Bergum (1997) speaks of the importance of the felt movement by a mother of her unborn child:

> Knowledge of quickening is the foundation from which to build a lifelong relationship between mother and child. Through quickening, the mother experiences the child in a way no one else can, and thus opens herself to her child through her body. She feels in her body the reality of the new life of another being. Through the experience of quickening, she begins to touch her child, to know her child—to be quickened and enlivened by the new life of her

child, and the new life for herself. Such knowledge, which can be seen as a moral move toward the Other, is not found in technological measures. (p. 22)

Not only is it not found in technological measures, but it is not encouraged by technological measures. By ultrasound, knowing your unborn child in his or her particularity through a close, personal, felt relation is replaced by a distant, precise, given technological knowledge. The relation of mother to unborn child becomes a reaction to knowledge given to her, rather than an awakening to the possibilities of herself as a mother through her unique bodily relationship with her child.

Lumley (1980) has reproduced womens' images of their unborn children during the first trimester of pregnancy. Some are "formless", some "unattractive", some "animal-like" (Lumley, 1980, p. 5). Yet, from these drawings it appears that women carry some image of their unborn child with them. Viewing an ultrasound image, and having that image interpreted to them, may alter their carried image in unexpected ways. The envisioned fetus may appear "pod-shaped" (Winer, 1994, p. 48), or, as in the case of twins, "two gestational sacs", or be seen as "two pulsating peanuts". However one describes the image, it is enlarged beyond what is real. The actual child may be no larger than a person's thumb nail, but on the screen the fetus becomes a "cosmic entity", one which may take on miracle proportions, "far beyond the mundane, scale of a simple, ordinary, female body" (Kaplan, 1994, p. 126). The pregnancy then assumes cosmic associations, and the child as a cosmic entity becomes disassociated from the mother and her body. It becomes a subject within itself, no longer faceless and limbless, no longer bound within the woman's body. It is *this* child on the screen, not *my* child within *my* body, of which only I have

knowledge. In its image on the screen the child becomes " 'seen'. . . possessed by all those watching" (Kaplan, 1994, p. 130). The contents of the woman's womb is up there on the screen, while her womb is here on the table, still within her body. The "safe haven" of her womb can be assessed and evaluated, based on the status of the fetus (Kaplan, 1994, p. 131). Repeated ultrasounds make sure that the womb is a safe place for the fetus to be. In a mother becoming the "maternal environment" for the fetus, the fetus has become the recipient of obstetrical care. The fetus has become a patient (Petchesky, 1987, p. 277).

Yet, even given these controversies, I do not suggest that ultrasound is unimportant to pregnant women or an inappropriate adjunct to their care. With a diagnosis of twin pregnancy confirmed by ultrasound, a woman (and her pregnancy) immediately are designated as 'high risk'. Some refer to this as high risk *status* as though one's state of pregnancy is raised higher by becoming higher risk. Hyde (1983) says that the way we treat a thing can sometimes change its nature. When we treat her pregnancy as if it is at greater risk than it was before her twin pregnancy diagnosis, then she assumes the persona of risk.

Women undergo repeated ultrasounds throughout their pregnancy, assessing the status of each baby. If one experiences a high feedback examination, their questions are answered (Reading et al., 1982; Stewart, 1986).[11] Questions about weight and size: How big are they? Are they the same size? Questions about position: Where are they lying? Who can I feel when I feel kicking here or here? Questions

[11]Women who participated in this study claim that the type of feedback given to them is dependent upon the whims, or perhaps garrulousness, of the technician rather than the type of ultrasound.

about movement: Are they moving? Are they making those breathing movements? Every answer to these questions solidifies the idea of a twins in a pregnant woman's thoughts (Van der Zalm, 1994).

> The last ultrasound I had—the lady was a lot nicer and that made such a difference. Like the lady that had done it two times before that, she was quite . . . she wouldn't let me look at the screen the whole time. She would only let me see it at the very end. She just wasn't explaining anything, wouldn't let me ask questions. So you sat there for and hour and a half, two hours, while she did everything and then you could ask questions. I found that unnerving. But this last lady that did it, she was just great. She let me watch everything and she explained everything that she was looking at. It's a lot more rewarding that way.

Seeing two, whether they are referred to as "two babies", "two pods", "two gestational sacs", or "two pulsating peanuts", reinforces to a woman that she indeed is carrying two infants. These visions, and the information provided by the ultrasound examiner, allow her to continue with the psychological work involved in carrying two babies rather than one

> . . . the excitement of when she measured them because already at 16 weeks, you know, we could see, they had fingers and they had legs and you could see spines and so they were really real. This was really happening. I was expecting twins. . . . because I go to those ultrasounds and I see them on a regular basis, it has become a reality. Like I know that this is happening. Like I know that there are two. (Van der Zalm, 1994, p. 79)

Without the evidence of the ultrasound image, without "seeing" those two babies before her, a woman has difficulty coming to terms with the diagnosis of twin pregnancy. Petchesky (1987) says that vision has become our primary sense, our primary means to knowing. In Western cultures the visual sense has become elevated in a hierarchy of senses, and as such, has the effect of "debasing sensory experience, and relatedness, as modes of knowing" (Petchesky, 1987, p. 275). Thus, even when she experiences other bodily behaviors indicating a twin pregnancy, a woman who "sees" two babies on an ultrasound believes that she is to birth two babies, and she can begin to prepare herself for that event.

With ultrasound, she has evidence of the gift she has been given, evidence that may take the form of a 'picture' to take home and show friends and relatives, babies' first 'photograph'. She can tell people what she saw, or perhaps she will tell people what she was told that she saw. "He showed me the screen and I said 'yeah, I'm supposed to be able to tell what I'm looking at here.' " With the image of her gift, her fears may be allayed—seeing two heart beats, seeing two gestational sacs. But as her fears about what lies within her body are allayed, new fears about what lies ahead during this pregnancy arise.

Having

"And oh God, I'm having twins." Womens' language of twin pregnancy says something about who they are and how they are. To 'have' has many meanings. To have is to possess, to own, to hold for use, to contain. In the most literal sense, a pregnant woman possesses the unborn children in her womb by virtue of their existence in her body, and in that sense she also owns them, as one owns their own

body and their blood connections (Campbell, 1992). She contains her unborn, as she holds them within her body. In the sense of 'to have and to hold,' she possesses them as one who will legally take on their stewardship when they are born.

"I'm not just sitting around waiting for this . . . ." To be having twins is to wait for two babies to be born, yet it is a different kind of waiting than waiting for a bus, or waiting for an elevator. Of course there is a difference. What she is waiting for is a birth. The felt quality of waiting, the subjective aspect of waiting, is an expectant waiting and a hopeful waiting when one waits for the birth of twins (Fujita, 1985).

While one waits for the birth of a single child, one trusts in the rhythms of the natural world, "tacitly knowing that we cannot influence them, that their rhythms are out of our control" (Fujita, 1985, p. 111). We trust in the power and process of nature and so we can wait until 'nature takes its course.' We take for granted that the end we desire will eventually happen, that the sun will rise, that spring will come, that in nine months time our child will be born. In this world of nature, the 'what is waited for' is clear and distinct. I wait for my child to be born. It will be a boy or a girl. I do not need to intervene or manipulate the outcome of this process. I just need to wait for it to happen.

A woman begins her pregnancy in just this mode of waiting, and then it happens—she is carrying two babies not just one. Her mode of waiting changes. The object of waiting, the child(ren) become more elusive. At first there are exclamations of "twins!" and effusive "great!" and "wonderful!" and "we are so lucky!" when the purpose of the waiting seems discrete, the end result of two babies "for the price of one". But as she waits, the discreteness of the end result may become indistinct,

vanish completely, or develop into a new purpose. "What will it be like to have two babies?" she asks. "I can't imagine," she answers herself. Her fantasies about motherhood, so critical to her self as mother, have not included mothering more than one child (Rubin, 1967b; 1972). As she realizes the complications of twin pregnancy for herself, and the risks for her unborn, her readiness to see a discrete end to this time of pregnancy diminishes and may vanish. The birth of twins becomes a hoped-for event that might happen sometime in the future rather than a discrete event that will happen in nine months time. The exact time of the hoped-for birth is not known, but it is at a certain vague moment in the future, its image indeterminate.

To realize a purpose in her new mode of waiting, what Fujita (1985) calls waiting in the world of becoming, requires abandonments of the old visioned discrete ends and the development of a new purpose. She must abandon her visions of birthing and mothering one child and forge a new purpose directed at a pregnancy and a life with two. The 'what is waited for' becomes more clear as she waits.

In the world of becoming, there is a dialectic between the objective aspects of waiting and the subjective aspects of waiting. 'What is waited for' influences the felt quality of 'how we wait'. Waiting for a single child to be born of a low risk pregnancy affects the feeling that a woman has of waiting (Bergum, 1997). Similarly, waiting for twins to be born of a pregnancy designated high risk affects how a woman waits. In both instances, the felt quality of waiting is an expectant waiting. To expect is to look forward to an event, to anticipate the occurrence of something. But in twin pregnancy, expectancy takes on another aspect.

To speak of expecting twins is to speak of undergoing, of enduring. To expect is to bear, *suf-ferre*, to suffer. "I'm trying to get through the first three months, that's what I'm trying to focus on more so. Like if I can get through that then I can get through the next few months." She waits for two babies to be born sometime in the future. "I'd sort of like to do that New Year's thing . . . . God help me if it's any longer than that. I hope that I can endure going that much farther. It seems like such a long way away you know just a couple of weeks." But she also bears enormous worries while she waits for something to go wrong: Will I miscarry before the end of the first trimester? Will I make it to 20 weeks when the pregnancy is considered viable? If I can do that, will I make it through that crucial time when the babies are the most vulnerable to prematurity? Will I make it to the time when they hit the magical weight of five pounds? If I can do that, will I make it to term without something going wrong? Will we all make it through the birth? She endures. She tries to "get through it".

> Okay I made it to 32 weeks, okay I'm passed that, I've made it to 33. It was like a goal, a goal, a goal. I said you know if I get to 36 weeks I would just feel fine. I could just have them at 36 weeks because then they're not premature anymore. If they just got 36 weeks in.

The spectre of the "difference" in her pregnancy haunts a woman. Because of the difference—carrying two instead of one--what could happen next? She waits for something to happen. "I kept thinking oh gosh what's going to happen? It's going to be just terrible you know. You didn't know what to expect . . . ."

Holding

When we are given a gift, we hold that gift and create a space for it in our lives. If it is a material gift, we may set it upon a shelf and take it down from time to time. When we see the gift or are reminded of it, it calls to mind the giver, and the circumstances around which the gift was given.

In pregnancy, a woman holds the gift of the unborn child that she has been given within her body. In a sense this type of gift is like an art work—imbued with a certain quality by the artist, mulled over, wondered at, and when finished, fully uncovered and released into the outer world for the benefit of others.

There is a third sense in which a gift can be given. If one has been given another type of gift, perhaps the gift of talent in art or music, then one is aware that it can be perfected through an effort of will, but that no effort in the world can cause its initial appearance (Hyde, 1983). This sense of 'giftedness' appears in the words and lyrics of a tune, and in a colored image on canvas. The artist or musician recognizes it when it appears. It is a nebulous quality of the gift that makes the work of the artist or musician authentic and exhilarating. Hyde (1983) calls this quality "the inner life of art" (p. xii).

Pregnancy is imbued with a similar quality of inner life. The artfulness of pregnancy is in its transformations--the fertilization of a single ova becomes a child, a woman becomes a mother--and in the immense creativity involved in the maturation of two cells into a developmentally sound and unique individual. In pregnancy, as in art, we cannot see how this sense of giftedness transforms the work. But we feel its strength when the work is presented to the world.

> Even if we have paid a fee at the door of the museum or concert hall, when we are touched by a work of art something comes to us which has nothing to do with the price. I went to see a landscape painter's works, and that evening, walking among pine trees near my home, I could see the shapes and colors I had not seen the day before. The spirit of an artist's gifts can wake our own . . . . We may not have the power to profess our gifts as the artist does, and yet we come to recognize, and in a sense to receive, the endowments of our being through the agency of his creation. (Hyde, 1983, p. xii)

And twin pregnancy has its own artfulness. A woman not only holds the gift of her unborn children within her body, but in receiving that "rare gift" of two unborn children, her pregnancy is transformed from the ordinary into the extraordinary. Her pregnancy's artfulness is manifested in yet another transformation—from woman, to woman-with-child, to woman-with-two. The giftedness in a woman's pregnancy is expressed in her own creative participation with her "rare gift", a gift that she holds in her body, nurtures, and then offers to others. Through the offerings of a woman and her twin pregnancy, as through an artist and his project, we are able to experience the extraordinary in ourselves, and in our world. "Art that matters to us—which moves the heart, or revives the soul, or delights the senses, or offers courage for living, however we choose to describe the experience—that work is received by us as a gift is received" (Hyde, 1983, p. xii).

Preserving

When we are given a "rare gift", we take custody of it. We become its custodian. We preserve it to ensure its continued presence in our lives. To preserve, *praeservare*, is to guard, to watch over, to keep safe from harm or injury. If I guard my gift as something extraordinary and precious, it retains its sense as a "rare gift". If I choose to treat my gift clumsily, with disregard, or to place a price upon it, somehow its nature as a "rare gift" is lessened. In my treatment of it, it assumes the nature of an object, a commodity, rather than a gift. In designating the gift as a commodity, with value outside of that which only I place on it, I am distanced from it and from its effects on my life. I look at it in a different way. As I recognize that it must have value to others, its sense of being only mine diminishes (Hyde, 1983). If, in pregnancy, we treat our rare gift of twins as one would a work of art, then we acknowlege that "a gift is carried by the work of art from the artist to his audience", that is from woman to world. It follows that "if I am right to say that where there is no gift there is no art, then it may be possible to destroy a work of art by converting it into a pure commodity" (Hyde, 1983, p. xiii).

If both gift and giftedness lie in pregnancy, how does one preserve both and ensure that the artfulness of pregnancy be offered to the world? When Hyde (1983) says, "the way we treat a thing can sometimes change its nature" (p. xiii), he helps us pose possibilities around this question. To preserve is to safeguard, to uphold, to shield, to defend. As religions sometimes prohibit the sale of sacred objects in the event that their sanctity is lost by the selling (Hyde, 1983), we must defend the gifts

of pregnancy by ensuring that the woman-with-two is sheltered and sustained in her wholeness, not objectified, or commodified.

"If our lives are gifts to begin with, however, in some sense they are not 'ours' . . . . only until such time as we find a way to bestow them" (Hyde, 1983, p. 97). As we take custody of the gift we have been given, we anticipate taking custody of the children after birth. As we preserve the gift during pregnancy, we anticipate bestowing the gift of these unique children on the community sometime in the future—the reciprocity of giving and receiving in pregnancy.

Gift Giving

The act of receiving is inextricably linked with the act of giving. When a woman receives the gift of twins during pregnancy, a series of complementary and reciprocal acts of giving begin. To give is to offer, to contribute, without expecting compensation. A woman gives gifts to her unborn children, and they, in turn, give gifts back to her. A pregnant woman gives gifts to others in her life, and they, in turn, give gifts back to her. When one receives, and then one gives back to the giver, "the interactive basis for a dyad, a group, and a society is established" (Zabielski, 1984, p. 20).

The body as the home

We speak of a woman's body as being *with child*, or in the case of twins, *with children* or more specifically, *with two*. Neumann's (1955) feminine archetype, the original pattern of femininity, is that of the female body as a container for the developing child, a vessel of containment, of enclosure. As Bergum (1989) points out, the female body viewed as a container for the child is not necessarily a negative one,

as if a woman waits for her "empty vessel" to be filled with a child, the offspring of a man, but can be viewed as a positive one: the woman as essential participant in the developmental process of bringing a child into the world (p. 54).

It is our image of 'vessel' or 'container' that carries with it a suggestion of carrying, transporting, holding. In this image, a woman's full and essential participation in the events of pregnancy are minimized. One cannot deny that a woman does carry her child during pregnancy, and does enclose that child within her body, but she does not *merely* contain and carry. During pregnancy, a woman gives her body as a home for her unborn children.

Home is from the Old English *ham,* meaning dwelling. It is in the home that one is sheltered, where one can retreat and find refuge. It is the centre point of a person's world or lived space (Bollnow, 1961), a space where one's self can be nurtured (Baldursson, 1985). James (1993) describes home as a place of safety, protection, and familiarity, its walls separating "the person from the outer, strange and potentially dangerous world" (p. 2). Until birth, a fetus is sheltered, protected, nourished, and nurtured within the walls of its uterine home.

> Before conception there is no obvious space in a woman's body for the baby. The uterus is only inches big: and as a hollow, pear-shaped, muscular organ, its ability to house an eight-pound baby is unfathomable. For the first three months, the baby's presence is not obvious to anyone, perhaps not even to the woman herself. She may know the child is there while finding it difficult to actually imagine. She may start to feel different: heavy, tired, sometimes nauseated, with morning sickness, with breasts that tingle and become tender.

> As the fetus settles and grows, it pushes the uterus out into the larger abdominal cavity and crowds the other organs. Within, and as part of the woman's body, the baby begins to show itself to the world. So it is both the expanding body of the woman and the developing fetus, together, that are creating the space for the baby. (Bergum, 1989, p. 54)

Women expecting twins accommodate two unborn infants, two placentae, amnion(s), chorion(s), and umbilical cords within their bodies. The usual description of the contents of the uterus--the products of conception—fail to capture the bulk of the entity within the uterine walls. As the babies grow, the outer perimeter of the pregnant woman enlarges, but she experiences her inner boundaries as getting smaller. The babies "take up a lot of room". Her outer increase in size is obvious and may be dismissed as just 'getting bigger'. But her size is an indication of the frenetic activity within. The babies push her both outwardly and inwardly, taking up more space in her outer world and eliminating empty spaces in their inner world. As they narrow their mother's inner space, she is constricted. "Everything's very tight. I'm having a lot more trouble breathing now. Rolling over at night. Like I always have to wake up if I have to move." They are heavy. Can her body hold them? "My bottom, my pelvic floor is just really sore. It's hard to walk, hard to bend or pull a boot off or that kind of thing." She is surprised that she is growing.

> . . . because all of a sudden I couldn't bend over to do up my shoes or I'd look in the mirror and go 'man I've grown in the last two weeks' or if I was outside with my husband working with the cattle I couldn't move as fast as I used to.

Or to get through spaces, in our corral system we have spaces in between boards and I couldn't make it through there.

As the babies grow, their own shared space within the uterus becomes smaller. Their behavior changes too as they feel the space restrictions of their uterine home.

I feel like there isn't a whole lot more room to grow in any direction. Their movement is more subtle, slower, less aggressive maybe or something. Like they're settling down a little bit more. Less room to move probably too. Less area to kick around in. Like it's not as busy a body as it once was.

As a woman's babies mature and grow within her, we see the outer picture of her pregnancy mature as well: a bigger body, a change in gait, breathing difficulties, manifestations of what the lay literature calls the 'discomforts' of pregnancy (as if they were minor dis-comforts, easily relieved so comfort could return). "I hate it when your ankles swell up. You just feel like a big balloon. Your hands feel like sausages. Only one pair of shoes will fit me . . . . You just feel like a big puff ball." "You just feel like you're blowing up."

My back hurt. I couldn't sit properly. The one on the right side was kicking me all the time and kicked me right up into my ribs, and pushed my ribs around. Either side that I laid on they were kicking. Constantly they were moving. I didn't sleep properly. I went to the bathroom a hundred million times. I felt like I lived in the bathroom.

It becomes an adventure to carry a laundry basket with twins. It becomes an adventure to find maternity clothes with twins. Panties, good luck! . . . I was

> huge . . . . sometimes it was hard to get up the urge to brush your teeth. I couldn't wash my hair or shower or bath. I could not shave my legs after four months. I couldn't get close enough.

It is as the felt space of her inner self diminishes, and as her outer self becomes bulkier, that a woman feels the growth of her babies. As they grow, she is physically separated from the world by their bulk. They are 'in the way' when she tries to do things that she used to do. With her pregnant body, she negotiates her world in a different way.

> In pregnancy I literally do not have a firm sense of where my body ends and the world begins . . . . In pregnancy my pre-pregnant body image does not entirely leave my movements and expectations, yet it is with the pregnant body that I must move. (Young, 1984, p. 49)

In sharing a body with her unborn children, a woman provides physical shelter and protection for her tiny, immature, vulnerable fetuses. In providing a home for her expected babies, she attempts to secure their "safe passage" to birth (Rubin, 1975, p. 145). She tempers such things as her nutritional intake, her exercise and rest patterns, her exposure to environmental hazards, and her occupational status. With two, she is more alert to the possibilities that they might not "make it" to birth safely.

> Just because there are two of them you know its double the responsibilities for them relying on the food that your body gives them. I think there's just more responsibility with twins just to keep them safe. I think with one you have a lot more room in your body to keep it padded for them . . . . I try to keep them safe by just not doing as much as I did with my first. To try and minimize the

chance of going into labor early as my doctor talks about just not walking very far and not going shopping all day. All those kinds of things, like carrying a lot.

Her provision of a safe haven for her babies may be complicated by the very existence of those babies. A woman who is experiencing a twin pregnancy is two, three, or more times more vulnerable to perinatal complications (Bowers, 1998; Guyer, MacDorman, Martin, Peters, & Strobino, 1998; Senat, Ancel, Bouvier-Colle, & Breart, 1998). Her body is the vehicle for the safety of her children, and sometimes in her desire to ensure their safety by providing them with space, food, warmth, a 'safe haven', a woman begins to feel that her body is not hers.

It's like you don't own your body. You have to live it for two other babies and you don't really have a choice you know. You take for granted the fact that you were really selfish with your body, you know that we take for granted the fact that you can choose when you want to eat, what you want to do, how you want to do it and even in the management of diabetes if you choose that you don't want to manage your diabetes and you don't want to exercise, you don't want to take care, you don't want to do this—that's fine. But you don't have that option when your're carrying babies.

As if it had been somewhere for a time—borrowed, lent, offered, used--women at the end of twin pregnancy "want their body back". Young (1984) sees pregnancy as a dialectic, where the woman experiences herself as both a source and a participant in a creative process. The word dialectic implies that the experience of one has profound effects on the other, and that when one 'gives' in the process, one gets

'back'. In twin pregnancy, perhaps there is an unevenness, a discrepancy, between a woman's experience as 'source' in the creative process and her 'participation' in the creative process, a point where 'giving' becomes 'giving up'. In wanting her body back, she wants her 'self' back.

Young (1984) also describes a woman's experience of carrying another within her own body as a de-centering, a splitting of the self. In pregnancy, she becomes doubled, herself but not herself, a woman experiencing herself as split between her past as *woman* and her future as *mother*. In twin pregnancy, a woman's sense of being changes in distinctly different ways from that of a woman expecting one child. Carrying two other beings within her body, her self is split into three rather than two. The inner movements she feels belong to two others not just one, and yet they belong to *her*. And, she is split not just between past as *woman* and future as *mother* as is a woman pregnant with a single child. She experiences splits from her past self as *woman*, as *woman-with-child* after a pregnancy diagnosis, as *woman-with-two* after a twin pregnancy diagnosis, and as future *mother-of-two*. Young (1984) suggests that a pregnant woman attends positively to the projects of pregnancy while her sense of self changes. In twin pregnancy, the work involved in attending to those projects is magnified by the numbers involved in her pregnancy and by the complexities resulting from those numbers.

Yielding the embodied self

"At the heart of Eloise's every act of giving existed a fundamental offering of self," says Zabielski (1984), when describing a woman who mothers undiagnosed twin infants (p. 32). In mothering, Eloise *offers* her self to her children, her embodied

self. To offer is to present: your offer may be accepted or rejected. In offering, we have a sense of how our offering might be received. When a woman is diagnosed with a twin pregnancy, she is compelled by the nature of her pregnancy to offer herself in a different way to health care professionals for the remainder of her pregnancy. In the offering, she yields her embodied self to what Terry (1989) calls medical surveillance. To yield is to give, but it is also to give up, to surrender oneself. She surrenders her embodied self to a more intense monitoring of her pregnancy. Surveillance, from the French *surveiller*, is to watch over, to care, to control and manage. To many of us, the generation of television and investigative journalism, 'surveillance' has a sinister connotation, "the watchful eye fixed on the suspicious character" (Terry, 1989, p. 16).

> Every little problem I was experiencing was open for discussion, and I was told how to act, what I could or couldn't do, what to eat, what to feel. I really wish I could have been more prepared for the loss of myself that happened during [twin] pregnancy. (verbatim written narrative)

In twin pregnancy, a woman is watched over, cared for, and she is directed to modify her behavior (and indeed if she does not, she is 'placed' on bed rest). All of these are intended to medically manage her case in what is deemed to be an appropriate manner. With this intense surveillance, a woman's consciousness of her pregnancy is transformed. She is no longer just a pregnant woman. She becomes a woman controlled by the nature of her pregnancy. "My lifestyle, the way I see things, you know, stress. Like I've changed everything in my life. It's completely different. I've had to. To try to make this pregnancy as smooth as possible."

They don't let you drive. You can't have sex. You can't even have a shower by yourself because they think you're either going to pass out or bleed to death . . . . It's just like they cut half of you off and they put it to the side and they don't ask you if they can do this. I understand medically that it was necessary. I didn't like it at all.

Although the medical community defines her pregnancy by the label 'high risk', to a woman expecting twins her pregnancy is changed, not the same as what it was before her diagnosis, but not necessarily risky. "I didn't feel I was [high risk] until they kept telling me I was." In giving up a pregnancy that is 'normal' and living the label that is 'risk', she gives up her own sense of what her pregnancy is about and tries to come to terms with what others deem her pregnancy to be.

I've always had awesome pregnancies and I've taken that for granted you know. And now it's very difficult. It's been a struggle you know, it's been an adjustment in terms of accepting the fact that I'm having twins. And it's a lot of elation—I'm looking for the right word here. You know it's really exciting and then you get a lot of attention, you get a lot of focus on you. You know it's good for my husband too. You're seen as very special by the fact that you're having twins.

Being different, not following the path of a 'normal pregnancy', having a label describe your pregnancy, can make one fearful.

Then going to these clinics and everything, I felt like I was this walking time bomb sometimes you know. I think that's just because, just going to that clinic I just wasn't a normal pregnant lady. Sometimes I felt like I was a ticking time

bomb waiting to go off. At any time it could happen. I think just the whole thing, high risk pregnancy, just that whole name, that whole term kind of sets you up for fear too—because you are not normal you are high risk.

In her 'specialness', a woman who is pregnant with twins undergoes many more doctors' visits and diagnostic tests. Her pregnancy is monitored carefully by health care professionals. Yet, in the ultrasounds, non-stress tests, glucose tolerance tests, biophysical profiles, who (what) is actually under surveillance? Is it her embodied self, her unborn children, or her pregnancy? Do we monitor *her* or her *risk*? When confronted with a woman expecting twins we commonly say, "She's high risk." And then our nursing assessment focuses on fetal growth (fundal height, maternal weight gain) and fetal well being (fetal movement, fetal heart rates), and we pay particular attention to information that we must learn to interpret (non stress tests, laboratory values). Other indicators of the status of her pregnancy might also be included in our assessment (the results of a glucose tolerance test, blood pressure, or our palpation of her uterus). But in all of these, how *she* is becomes a reflection of how *they* are. The assessment of *woman* is lost in our assessment of the *two*. And she is watched as an indicator of the status of her unborn. We engage with the fetus(es) through discrete physiological indicators rather than through the woman who carries them in her body (Squier, 1991). And a woman begins to take her cues about her pregnancy from her health care provider(s) and their interpretations of what is happening within her rather than from her own embodied knowing. "It doesn't concern the doctor so of course it wouldn't concern me. Because if it doesn't concern him it doesn't concern me."

Feeling the Others

> I remember sitting quietly when I was pregnant and I would close my eyes and gently touch my belly and feel the life and movement inside of me. I was so proud—so alive. Imagine my body growing, swelling, giving life to two small creatures (?) babies. It was amazing. Sometimes I would just feel like I was floating on a cloud. I was so peaceful for those few moments—I was so proud. I was in my own world—sharing those emotions and thats thru touching my belly and feeling—with two little babies growing inside me—my belly just kept growing—it was so round and beautiful. I loved my belly. It was beautiful!! Thank you God. To feel their movement—little elbows and knees and heads rolling around. (verbatim written narrative)

Not only are gifts of the body given from mother to child, but gifts 'of the bodies' from children to mother. Bergum (1997) says that it is in experiencing quickening, the first felt fetal movement, that a woman recognizes the social nature of human life: "It is an awakening of reality to another being" (p. 97). Feeling the life within her, a woman says, "I am going to have a child." She focuses inwardly on what others cannot feel from the outside. It is " 'me and the baby' " (Bergum, 1997, p. 165). She is *with* the baby.

> And then, suddenly, I felt this tiny flutter a bit below my belly button. A tadpole flicking its tail. A ripple, a wave. Instantly that image of the tadpole—an image I'd probably pulled from some high school biology textbook—changed to that of a newborn baby. I knew my baby at that moment looked nothing at all like a newborn. But that was what I pretended was fluttering

> inside me. A psychedelic little person doing the breaststroke in a lava lamp. A bubble bouncing euphorically, but in slow motion, around in my tummy. I saw a newborn's pudgy fingers flicking amniotic fluid with a whoosh, I saw little feet smaller than baking potatoes gently splashing my own water against me, and I wrapped my arms around me and hugged my baby through my belly. (Bohjalian, 1997, p. 179)

But with twins it is "me and them". Women who are pregnant with two can discern movement within their bodies, can feel the quickening, but at the moment of quickening cannot discern which child is making the movements. It is the "babies" moving, not *this* baby. In quickening, one's attention is turned to the Other but experiencing the Other as reciprocal, mutual, and sharing is elusive, ephemeral. One focuses instead on: Who am I sharing this moment with? This one or this one? Or both?

> I had a hard time, going two, there's two. I didn't know where to put my hand. It just seemed to me that was a hard thing for my brain to wrap around that there was two in there and who am I touching and who is doing what.

If a woman finds out she is expecting twins early in her pregnancy, her sense of feeling the Other at quickening is changed. She is "claimed" by two (Bergum, 1997, p. 166) rather than one. Sometimes, it is quickening that brings the feeling that something is different with this pregnancy. There is too much movement. It doesn't feel quite right. It is only after receiving a twin diagnosis that the difference she felt makes sense. "I can feel them differently now whereas before I really seemed to only

feel the one, and maybe it was different ones at different times, maybe they were just moving around. But in my head it was one."

Fetal movement equals fetal well being. When a woman feels her unborn children move within her, they are "okay". Not only are they "there", but they are "healthy". As with a single unborn child, in twin pregnancy there is a reciprocity in the touching. She feels the movements within her, "like a gurgle, water coming to a boil, with bubbles coming up" (Bergum, 1997, p. 165) or like "gas bubbles", but also can outwardly feels them through skin, muscle and the uterine wall. But in touching them, there is a sense of question. "Who am I touching?" she asks. At first, a woman feels "them". "I like it when they move." "You can feel them at different spots at the same time."

> I can feel what they are doing all the time . . . . It's really neat when you can feel them really dramatically. They do things, like sometimes you can feel their foot or something and it doesn't move, and it's sticking right there and then you get a real dramatic movement somewhere else.

Later in pregnancy, when the palms of her hands as "point of departure" discover the presence of two babies (Buytendijk, 1970, p. 114), the limits of the space that each occupies, she begins to recognize their movements. "They" become "this baby" and "that baby." "The one that's head is down further used to be the busy one and has really slowed down." "I really think that Baby B is stronger." The quickening towards the child, never a smooth one says Bergum (1997), is more complicated with two unborn children—one must awaken to two new lives and discover the presence of two separate beings.

Being community property

"I remember when I was pregnant I became community property." In some primitive cultures, there is a belief that a part of the giver's self is present in each gift. "The self spirit in the gift constantly strives to return to the original donor, constraining the receiver to present this person with a gift of his own" (Zabielski, 1984, p. 22). Can it be that in offering oneself, pregnant self and unborn, to her community of friends, relatives, strangers, and in yielding oneself to medical scrutiny, that others are compelled by the spirit of the gift—an irreplaceable, fresh, unsullied, human being—to present a woman with their own gifts, gifts of themselves? And their gifts take the form of looking, asking questions, giving advice or telling stories about themselves or someone that they know. Perhaps even in telling "horror stories" about pregnancy and birth, their intent is not to hurt or to harm, but to caution or to inform. When a woman gives her gift of a child to her community, they respond, with the hope that the spirit of the gift will flourish so all can benefit from it.

With twins, the gifts from others seem magnified, out of proportion, exaggerated. Perhaps that too is a reflection of the magnitude of her gift. "There's just so many people that seem to want to know because it's twins." Because twins are an "honor", "a blessing", and a "privilege", women who are carrying twins receive more attention from others. Only a few of all pregnant women carry twins. When a woman is "blessed" in this way, her community too will be "blessed" with the safe birth of two infants, surely an event for extra celebration. The "blessing", a special favor usually connected with God, connects woman and community in an out-of-the-ordinary way. In this special connection between giver and recipient, the community

is invested with a feeling of ownership and in the spirit of giving wish to return the 'favor'. *The* babies become *our* babies. A woman carrying twins is cared for by the community. She is touched, questioned, offered advice and assistance. She receives phone calls from individuals she hasn't spoken to for a long while. She is given "celebrity status" at work, at her children's school, and at her health care professional's office.

Literally, "community property" is to be jointly owned by oneself and others. One's ownership of something is shared with a community of others. It is in the sharing that one gives the gifts of twin pregnancy to others, and it is also in sharing that the burdens of twin pregnancy can be eased.

The Gift Relation

Gifts connect one to the other. "Gifts are better for initiating and sustaining more rounded human relationships, where future expectations are unknown, and where the exchange of goods is secondary in importance to the relationship itself" (Murray, 1987, p. 31). It is not *what* is given, or *what* is received that are the only meaningful aspects of gift giving, but the relation that is called into being through the acts of giving and receiving.

To speak of the gift relation is not to speak of the gift as merely an object, binding the giver with the receiver, as in "Oh Jane gave me that for Christmas last year". It is to speak of an involvement of people and a kinship of blood and family that reside with the acts of giving and receiving. One may place value on an object that is given and received, but the gift relation is prized, yet priceless (Hyde, 1983).

The gift of twins brings into being a special relation. Twins bind one mother to two children, in a particular space and time and in a particular cultural and social context. At the same time, two children claim one woman as mother. They also claim each other as sibling, as twin. They have not existed without the other. Twins "have always been together".

A woman may be a mother, but to be a mother of twins, she must carry two children and birth two children from the same pregnancy. A twin is "one of a pair", one part of a two part "unit". Twins are "together", are "close". "When I think of twins I think of identical twins." Their twin-ness is immediately declared in their same-ness. They are alike. When we see two people that are alike in this way, we assign them the name, twins. "Identical twins get more twin treatment." To be treated as a twin, they are "kept together", allowed to have their "twin relationship". To have a twin relationship is to "have a very close relationship", "to depend on each other", "to be there for each other", "to have many different things in their lives but they'll still have each other". Twins "do a lot of things together", "spend a lot of time together". To be a mother of twins is to give her children "the opportunity to be twins or to be able to depend on each other", "not separating them".

The twin-twin relation lies in their connection with each other, an "extra special connection". Twins occupy an intra uterine environment, a womb, from conception until birth. We listen to women who tell us what it feels like to have two unborn children in their bodies. With modern technology, we can see inside the uterus. We can watch them move together, and observe them press on each other. From the outside, we can feel them move and imagine how they must push each other

this way and that way. Do they compete with each other for space? Or do they share space? Can they touch each other through the amnion? Through the chorion? Is their connection only touching, competing, sharing, or is their blood transfused from one to the other? What is it for twins to share blood connections in this way as well as sharing placental connections with their mother? Does it make them less 'themselves' and more 'each other'? Does it make them more 'twins'? Murray (1987) says that our loyalties and attachments are defined by blood. It is blood that shows us our kinship and binds us together as family. In their blood connections and in their intra uterine proximity, are twins more kin than ordinary siblings who only share an extra uterine environment? Fraternal means brotherhood. In their sharing of blood in a family sense, during the journey through the birth canal, and perhaps in a physical sense during twin-twin transfusion, all a 'blood brotherhood', do not all twins share a fraternal relation? Instead of viewing non-identical twins, 'fraternals', a lesser form of twin because they are not identical to their sibling, all twins, through their blood connections, are fraternal.

The intricacies of twin and placental physiology raise interesting questions about connection and relation. We can answer some of the questions with physiological answers (there is this amount of fluid in the womb; the babies weigh this amount; they take up this amount of space; there is one chorion and one amnion present, therefore the twins are monozygotic). But the intra uterine experience and what it is like for twins remains a mystery. We speculate on what it might be like. Do we assign relations between twins based on our speculations, on our expectations? They are together in the womb, therefore we expect and assign togetherness?

Together, from *togadere*, means to bring or draw into one group, to-gather (two-gather). Physically, before birth, twins are together in the womb. After birth, we continue to link them into a unit, based on their twin-ness, and/or their identical-ness.

By being given two babies, a woman becomes a mother of twins. The maternal-infant dyad of a single pregnancy is doubled (Zabielski, 1984). Or is it merely doubled? With twins a mother has a link to each twin, and each twin has a claim to mother. A woman also claims "the twins", the unit, as her own, and the unit claims her. In receiving this gift of twins, she is not only a mother, but she is a mother of *this* one, a mother of *this* one, and a mother of *twins*.

Chapter Seven

The Birth

> *The rarity of plural births in women and increased danger to mother and offspring in these circumstances render such an event in a certain limited sense a disease or an abnormality.*
>
> *Duncan (1865), p. 928*

When the term 'birth' is mentioned, we feel its familiarity in our lives. Because of a birth, a day becomes a birth-day, a location becomes a birth-place, a gem becomes a birth-stone. With birth, something happens, and the old order of things deserts us. 'Birth' speaks of a coming into existence, an event, an initiation. We also speak of 'birth' in a different yet still familiar way, as the act of bearing or bringing forth offspring. Through a biological process, a woman actively births a child. A woman's act of birth—birthing--is an event, signaling a coming into existence of children. Birthing initiates a woman into biological motherhood.

In conversation about birth, women speak of "deliveries" rather than 'births', and of "being delivered" rather than of 'giving birth'.[12] Women are delivered of their children rather than bringing to birth their own children. When a woman "delivers", her own active participation as the agent of the act of birth is not acknowledged. Even though she is physically present, and the labor progresses physiologically, and the birth of children eventuate as a result of the process, in her language of birth, her active *birthing* becomes passive *delivery*.

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[12] This change in the language of birth has been noted by scholars who study the evolution of birth practices. In the majority of twentieth century Western cultures, birth is viewed as a passive process through which a woman is taken by another person (Davis-Floyd, 1989; Goldsmith, 1984; Mitford, 1992; Rothman, 1982; Wertz & Wertz, 1979).

Readiness

One anticipates a singleton pregnancy to last approximately 9 months or 40 weeks. For a woman who is pregnant with twins, the time of birth may not be the anticipated 280 days from the time of conception (Bryan, 1992). The time of birth could be today, tomorrow, next week, one month or three months hence. Birth may occur on or about her 'due date', earlier or later. Any time could be her time. The time of twin birth is not predictable. She lives with not knowing when her time of birth might come. Birth could occur here, or here, or here, or at any time on the gestational calendar, but hopefully it will occur *after* the twentieth week, *after* the twenty-eighth week, *after* the thirty-fourth week, *when* the babies are big enough, *when* the babies can breathe on their own, and *when* they are well enough so she can take them home. So, rather than *getting* ready for a birth that will occur sometime during the last couple of weeks of a forty week gestational period, a woman carrying twins must *be* ready for an imminent birth.

There is preparation in getting ready for any birth. For a woman expecting a single child, preparation for birth includes getting things ready—baby's clothes, baby's room—and also educating herself about the labor and birth experience. Women take responsibility for getting ready: "By taking the course on prepared childbirth, I was already doing something active and deliberate to make my pregnancy and labor a manageable and knowledgeable aspect of my life" (Levesque-Lopman, 1983, p. 260). As Bergum (1989) says, the bags are packed, a birth plan may have been discussed with the doctor, and a woman has chosen the person that she

wishes to have with her during labor and birth. In getting ready, she gets physical things ready. But she also interprets the signals of her body that tell her that her 'time' of birth is drawing nearer. She moves slowly, and she is plagued by sleepless nights, visits to the bathroom, indigestion, flatulence, and constipation. Physically, she is ready for birth.

For a woman expecting twins, readiness for birth does not lie to the same extent in getting things ready. Reluctant to prepare for two in case "something happens" or "anything goes wrong", she waits while her pregnancy moves forward. "You don't get too far ahead in your thoughts." "I just drifted through the days." "You only think about as far as you are now." Getting things ready, like buying two cribs, two car seats, and so on, comes late in her pregnancy or perhaps not until after the birth. "When we see the babies, then we will start doing stuff."

Readiness for twin birth lies in *being* ready. Being ready for the birth of twins is a mental willingness to meet the unknown. What will happen in labor? In birth? How is it going to be different than my last baby? How am I going to get through it? During twin pregnancy, the questions are unanswered, even for women who seek answers through attending prenatal classes.

> In the prenatal classes, I didn't really belong in the group. Everything was geared towards one pregnancy and you know what would happen in two? How do you breastfeed twins? So you are sitting there and it's sort of like this doesn't pertain to me and you're kind of nervous about asking because it's sort of like when you're having twins everyone says like "Oh really oh. Are

there twins in your family?" You know all these questions and things like this . . . I wish I had gone to a prenatal class that was just for someone expecting multiples like twins. Not even triplets. I guess I just wanted to go this is a twins thing. I want to go there and hear what they have to say about that. I think I felt a little bit apart in that throughout the whole prenatal thing. This is what labor and delivery is like. You know I was like, okay, when you deliver vaginally do you deliver one placenta with the one baby first and then the other baby and the other placenta? How does that work?

I had to try to sort out how am I possibly going to do all of this. . . . How am I going to successfully breastfeed? . . . How am I going to manage that? How am I going to manage nights? Or how am I going to manage to get these guys on a schedule? All those kinds of things . . .

To become ready to face the unknowns of labor and twin birth, a woman listens carefully and interprets what she is told about her unborn babies. To her, more is better. The bigger their size, the greater their weight, the longer their gestational age, the more she can put aside her worries about the health of the babies and the more she can focus on labor and birth. She physically may feel that the time of birth is near, but she wishes birth to come only if the time is right. "I kind of wish it was over yet I know if I wait a little longer the babies will be that much better off." "I want to last longer for obvious reasons, like I want to make it to at least 34-36 weeks, but I would like it to be over at the same time. It's just exhausting."

A woman's time of twin birth might come before she is ready. With premature twin birth, a woman's future somehow seems even more unknown.

> I was really worried. I didn't know what to expect. I didn't know what our future was going to be. Whether we're going to have two babies, one baby, two babies with mental handicaps or physical or any problems. My biggest concern was what will I do?

> We're going to have babies soon and look at them [health professionals] down the hall—there's a little anxiety. I'm not over excited like you are with a normal pregnancy. I think part of it is because I'm not at term. I'm not prepared, I'm not at term. Maybe just mentally I'm not ready I don't know.

When a woman enters the hospital, gestational time prevails. Her readiness for twin birth becomes secondary to the calculation of the gestational age of the babies—how much time have they had in utero? Are they mature enough to survive in the extra-uterine environment? If they have not had enough time, medications can be given to stop her labor and to help the babies' lungs to mature faster. Sometimes, her time of birth can be delayed. And sometimes, if gestational time shows that the babies have been in utero too long, medications can be given to induce her time of birth, or even to speed up her labor if it is not progressing according to 'textbook' time, or with what 'time' is believed to be acceptable.

A woman's time of twin birth is distinguishable from other 'times'—two babies are expected this 'time'. Is that why this 'time' is not "normal", not "natural"? Is it beyond what one can ready oneself for? It's not like the birth portrayed in film, or

television, not like the birth of a friend or a sister. "Mentally It was just like a ball of what ifs."

In travail

> Because I had the epidural[13]. . . at the point where it was wearing off I was going from where there was no pain to where there was a lot of pain. They brought the laughing gas, so use it. They didn't tell me how or when and what not so I had it on between contractions for two contractions and I started to feel a little dizzy and I felt like I was falling off the table. It was like I had no control . . . . I went into tears and I was hysterical but the labor . . . [What did the pain feel like?] It hurt. I don't really know, because I wasn't really concentrating on the labor and the delivery. It was too . . . I was concentrating more on what's going to happen? Are these babies going to be born alive? Are they not going to be born alive? I wasn't thinking of what was happening right then because I was trying to rationalize through my head and because people were all coming in and blabbing about statistics and all their stupid numbers and everything else. I just wanted to get through that and make sure my babies were okay. It was getting through it. The pain was . . . I knew I would have to go through that pain. . .

Childbirth and pain are linked. We acknowledge that the birth of a child, with its dilation and thinning of the cervix, distention and pressure on the pelvic floor,

[13] An epidural is analgesia of the lower half of the body. An anaesthetic agent is administered into the epidural space of the spinal cord. This type of analgesia can be administered alone or in combination with other treatments such as narcotics, nitrous oxide, instrument or operative deliveries (Thorp & Breedlove, 1996; Waldenstrom, Borg, Olsson, Skold & Wall, 1996).

traction on peritoneum, and pressure on bladder, urethra, and rectum, is physiologically painful (Lowe, 1996). Yet, when we speak of a woman's birth experience we speak of her 'labor' rather than of her 'pain'. 'She had a very long labor', we say, rather than 'she had a very long pain'. The term labor is associated with productive activity, with hard work in getting a task completed. The result of a pregnant woman's arduous labor is a child, and in the case of twins, we have one labor ending in two separate birthing events. To labor to produce a child is also to be 'in travail', which comes from the Latin *trepalium* meaning torture chamber. To be in labor, then, is to be tormented, to be tortured, or as Rich says (1986), "to be invaded by pain" (p. 163). For a woman expecting twins, there is added torment to the physical pain of labor and birth. In the forefront of her mind, is the uncertainty of outcome in twin birth, what professionals call the high incidence of morbidity and mortality, especially when the birth is premature. On the threshold of twin birth, a woman still does not know whether the physical work she is doing now, and indeed has done for the past months of pregnancy, will yield one child, two children, or none. When she "gets through it", when "it's over", she will know.

We think of pain, torture, and torment, as something awful, as something to be avoided, as something that we cannot endure, and yet does the pain of labor and birth not have its own importance? Bergum (1984) says:

> To have experienced birthing pain offers the possibilities of self knowledge, knowledge of our limitations and capabilities, knowledge of new life, as mother, and of our place in the mysterious cycle of human life: birth, death, and rebirth. As we birth our children, we, in a sense, birth ourselves. (p. 186)

The pain of birth brings us face-to-face with our self as we become a mother, and the pain of two separate births at the same event brings us face-to-face with our self as a mother-of-twins. Within the pain and the work, a woman knows that her time of birthing has come, that this is the final step in her pregnancy, that it is not long until she will see her child(ren). Wertz and Wertz (1979) speak of birthing pain as "a desirable evidence of the life force that ensures a mother's love for her offspring, a kind of psychological imprinting" (p. 117).

Given the significance of pain in childbirth, it is ironic that many measures have been devised during this century and previous eras to eliminate birth pain. Much of modern day obstetrical care is based on the premise that a woman should not suffer pain during childbirth (Mitford, 1992; Rothman, 1982; Wertz & Wertz, 1979). Birth without pain has become a goal for many women. Lowe (1996) says that without the spectre of pain ("one of many stressors with which a woman must deal during labor") womens' anxiety about birthing is lessened, they are more confident with their ability to stay in control during the labor and birth, they feel that they have a sense of mastery of their labor experience, and so they are generally more satisfied with their birth experience as a whole (p. 83). Eliminating physical pain, then, would appear to be a great advantage in childbirth.

But what happens when we do eliminate the physical pain of childbirth? What happens when we cannot feel our legs, or the localized pain in our pelvic floor, our perineum? What happens when we have no sensations to tell us how our labor and birth are progressing, or even that they are? What happens when our interventions eliminate womens' deep inner birth pain, that "which expresses itself as 'being in

pain'. . . . this inwardness . . . the feeling of unreality, of being in a fog, a sense that time has stopped or is irrelevant, with little awareness of the people around" (Bergum, 1984, p. 184). If these sensations are missing, is that not being out of control during birth? The word pain, from the Greek *poine*, means penalty. In being relieved of pain, are there other penalties that we pay?

> It [epidural] just takes all the pain away. But the bad thing is that you don't feel the pushing. And they keep on saying, 'Aren't you ready to push?' Nope, you just don't have that striving anyway or sensation at all. It wasn't physically uncomfortable except for the part not being . . . it was very uncomfortable not being able to push. It didn't hurt but it was very. . . like I didn't want Hannah having to have a vacuum extraction, just let me push. Like I wanted to push. I could have got her out but they just . . . who can push flat on their back without their feet in anything? Even normally.

Having relief from painful uterine contractions does not necessarily mean that there are not other things that make this twin birth painful. There is pain in being unable to respond to what your body is urging you to do. And there is pain in knowing that when you cannot respond, other things happen, medical interventions that you don't want to happen, like vacuum extractions, forceps applications, caesarean sections. Things that a woman does not want to happen to herself or her twins. Labor pain focuses a woman on the work she must do to push a child out of her body. When we have the ability to eliminate the pain of labor, we change her focus from her work and pushing, her active inwardness in bringing this child into the world, to the relief of her pain. When her pain is relieved, then we must re-focus on

the response of her body—can she push? Does she need help in getting the babies out? In eliminating her birth pain, a woman's birth becomes centred upon her inability to actively participate in birthing.

When all sensations of labor have disappeared, the pressure, the stretching, the movement of the first baby and then the second baby through the birth canal, the intensity, concentration, and involvement in the work that must be done, a woman is a spectator at the birth of her own twins.

> So they didn't have to do an episiotomy on me, nothing. She just came and they delivered her. I don't remember having any pain because of the epidural . . . . It was probably about five minutes we waited, and then I felt like they had to kind of push the next one, the one on my left side down. They had to kind of bring him down a bit because he was up quite high at that point.

There is another kind of pain at the birth of twins—not "being there" at all. When a woman and her medical professional decide that she will have an elective operative birth, then there is no labor, no active work on her part, to prepare her body to push her infants through the birth canal and into the world. For a woman who has a general anaesthetic and is 'asleep' for the birth of her twins, she awakes to surgical pain, and to the pain of having someone else tell her about the birth. And someone else introduces her to her children.

> I actually saw him [first born singleton]. It's like I saw him coming from me. Like there's a part of me that has sort of physically–like they've taken him out. I pushed him out you know and here he is, whereas with Alex and Adam [twins] it was like I woke up and it was sort of like 'you're sure they're mine?'

The arena

> But the horrible thing was when they took me into the, they take you into an operating room instead of a birthing room just in case there's problems because they're twins. Plus everybody and their dog wants to watch. There was like twenty people in the operating room. They have you on this little stretcher instead of a birthing bed and they hold your feet instead of you being able to hold onto anything else. They push. You don't have any sensation plus there is the little nurse trying to hold you. "Stand me up, let me push." And they wouldn't. Laying flat on your back, you have all these monitors on. It was ridiculous.

The place of twin birth is filled with people—obstetricians, pediatricians, nurses, anaesthesiologists, students. It is filled with noise—the galloping of two monitored fetal heart rates, the ripping of paper and plastic enclosing items necessary for 'delivery', the clanging arrangement of metal birth instruments and basins, the opening and closing of doors, the rustle of papers, the hushed and not-so-hushed speech. The noise level, the number of people in the room, the foreign instruments, the bright lights aimed at her perineum, the sanitized smell, the shiny tiled walls, and the narrow operating table on which she lies, is a vivid contrast to the dim lighting and comfortable bed of the quiet birthing room down the hall. It is a place of machinery. Each contraction and each fetal heart beat is electronically monitored by a wire from mother to machine, and from baby to machine. The wires that communicate this mother-baby-baby information appear at the edge of the sheet that covers her legs, snaking upwards to her right and left, inserting into the face of the

machines at each side of the operating table, like umbilical cords inserting into placentae. The monitor's stylette draws the arc of her contractions on the paper monitor strip. At the top of the paper, the baby's heart beat appears. Sometimes it seems that it is the machine that keeps the contractions coming and the machine that keeps the baby's heart beating. The blood pressure cuff on her right arm inflates and deflates on its own schedule, automatically recording its reading on yet another monitor strip. The infusion pump regulating the intravenous in her left arm draws fluid into its infusion chamber and 'beeps' its readings into the room.

The place of twin birth is a place where every aspect of labor and birth is monitored. Bergum (1985) says that the word monitor is from the Latin *monere* and literally means "one who warns" (p. 8). It is through being monitored to this degree that a woman senses the gravity of her labor and birth situation. In this place of twin birth filled with machines and strangers, something is expected to go wrong. It is necessary to be in this place with these birth attendants, "just in case something goes wrong". And it is the machinery that tells professionals that something is wrong with the birth process. The woman, as the active participant of this birth, takes a role secondary to the electronic monitoring equipment. Technological assistance (assistants?) will inform the medical professionals when they need to intervene. In this place, she understands that she cannot give birth without help.

Health care professionals intermittently check and interpret the data from the machinery surrounding her. The place of twin birth is a place where medical professionals are in charge. The incidence of twin birth complications is higher than that of single births (Baldwin, 1994; Bryan, 1992; Harvey & Bryan, 1991; Niermeyer,

1990), so a medically managed birth is considered a safer birth (Ashford, 1986; Rothman, 1982). To caregivers, their presence at a twin birth is necessary to ensure that the birth is 'uneventful'—meaning that the birth outcome is positive.[14] A positive birth outcome is two live infants (with as few birth complications as possible) and one live mother (with as few birth complications as possible).[15] The twins will be born into a bright, clean, technologically monitored, professionally staffed environment. Specialists are present to care for the woman and her infants—one 'team' for each baby, and one 'team' for mother. Some professionals are present just to witness this event, to see a birth that is out of the ordinary and some are present to acquire new skills in assisting women to deliver their infants (Bryan, 1992).

For a woman expecting twins, birth is "a circus", "a sideshow". "Every two minutes someone would come in and say 'Hi I'm Mary Jo, an intern, and I'm going to be observing the birth'. And I was thinking, Oh God are all these people going to watch?" To enter an operating room is to enter the arena of the professional. It is a place of ritual where others are in control (Davis-Floyd, 1992). It is in this place that

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[14] Robbie Davis-Floyd (1994) says that the most desirable end product of the birth process is a new member of society, the baby. The new mother is a secondary by-product of this process.

[15] Childbirth experts of the World Health Organization's Technical Working Group define the aim of care in a "normal" birth as: "to achieve a healthy mother and child with the least possible level of intervention that is compatible with safety. The approach implies that in normal birth there should be a valid reason to interfere with the natural process" (World Health Organization, 1996, p. 121). They also note that the "labor and delivery" of high risk pregnant women may follow a normal course, so these births should also be considered "normal" and thus the care of the "normal" applied to the care of these high risk women (WHO, 1996, p. 121). Recommended birth practices for normal childbirth include: personal birth plan determining where and by whom birth will be attended; ongoing risk assessment during pregnancy and labor; respecting womens' informed choice of place of birth; providing care in labor and delivery at the most peripheral level where birth is feasible and where the woman feels safe and confident; respecting the right of women to privacy in the birthplace; non-invasive, non-pharmacological methods of pain relief during labor; freedom in position and movement throughout labor; encouragement of non-supine position in labor (WHO, 1996, p. 123).

the rites of passage from woman to mother-of-twins are orchestrated and enacted. The term arena, from the Latin word *arena*, means a place for combat. In this arena of birth, the professionals and the birth are adversaries. As opponents, one must 'win' over the other.

In this place, a woman is monitored, observed, palpated, and probed. She is subjected to the activities and questions of others, while they observe the effect of their actions and evaluate her behaviors. If we do this, or this, or this, does it make any difference to the descent of the head, to this fetal heart rate, to the strength of the contractions? She listens for the sound of the babies' heartbeats and worries between contractions: Can you still hear them? Are they slowing down? Speeding up? Too slow? Too fast? Am I doing something wrong? The positive energy of the birth experience as a whole is lost as a woman becomes the subject of ritual, an object under scrutiny, both inwardly and outwardly exposed. She is the source of something going wrong, "rather than that the process of labor *itself* is worthy of attention or support" (Bergum, 1985, p. 8).

The unfamiliar is common in the place of twin birth. The mother wears a hospital gown instead of her own clothes. Noise and confusion take the place of dim lights and quiet. Strangers walk in and out of the room. In this unfamiliarity, her ownership over her birth is lost. Others interpret the birth of her children to her. Her body becomes as unfamiliar to her as the place of birth.

We, me, and they: the separation

To separate is to take apart, and in so doing, set apart. At the time of twin birth, a pregnant woman's embodied self is transformed from 'me' and 'we' to 'me'

and 'they'. Birth sets a woman apart from her twins. 'They' are twins: 'they' are this one and this one. But it also sets apart, separates, her twins from each other. For a few moments at birth, it is 'me' and 'baby'. She can look at, and perhaps touch, her newborn for a few seconds. But the moment is quickly lost as another contraction builds, a physical reminder that her release from travail is not yet over. She must focus on the work of birthing another child.

> And then I was upset because I didn't get to see her, and then I had to concentrate on getting Denise out. But then as soon as Denise was born, which was an easier time, still uncomfortable but they figured out something I could hold my feet on, so I could push a little bit better. I got her out, she just had forceps, and they gave her right to me which was good.

To see her twins at birth a mother begins to set them apart, from each other and from herself. But twins are often 'special cases', 'at risk', or premature, and need to be taken away from a woman in order to be cared for or observed by experts.[16] She may not see them at the birth or indeed for many hours after.

> Like you see in the movies all the time that 'it's a boy' or 'it's a girl'. You know you get to hug and kiss and all those fun things. I didn't get to hear them cry. I didn't get to see them. I knew what they were because my husband told me what they were, but I didn't get to see them. And not knowing I think was my biggest fear, but yes they were all right and yes they were really here. What

[16] Davis-Floyd (1994) says that the separation of mother and baby at birth demonstrates to mother society's ownership of its product, where "the mother's womb is replaced not by her arms, but by the plastic womb of culture" (p. 1127). Therefore, the baby is *ours* not *hers*, and can be cared for adequately by someone besides his/her mother. Of course, in instances of prematurity or illness, babies require care that must be given outside of the 'delivery' room. In those instances a baby must be 'given back' into his/her mother's care.

upset me I think the most in my whole pregnancy was not seeing them after the birth.

At birth the separation of twins goes beyond being physiologically and physically separated from mother. They are physiologically separated from each other, no longer entangling with each other within the close confines of the womb, no longer sharing amniotic fluid and/or perhaps a blood connection. And they may be physically separated from each other. One or both twins may be taken from the 'delivery' room and taken to an intensive care unit for treatment and/or observation. Often one baby is on one side of the nursery and the other baby is on the other side.[17] And mothers who have just delivered their twins may spend the immediate minutes and hours following the birth without their children, without their partner, wondering about the baby or babies that are being cared for somewhere else by someone else.

> I was worried about her. I didn't know why they had taken her away. . . . I didn't get to see her. There's pictures of my husband holding Darcie in the nursery before I even saw her . . . which is nice for him but I didn't get to see her .

Some women don't remember the moment that they saw their first-born twin. In the noise, confusion, and continuing pain, the moment of 'meeting' their child is lost. A woman must concentrate on "getting the next one out". Immediately, after the births, from her vantage point lying on the 'delivery' table, she can see two separate groups of health professionals. Each group surrounds a baby who lies naked in an open warmed crib. They are assessing breathing and heart rates, checking apgar

scores, and keeping the baby warm. The babies are the focus of attention. When the baby assessments are complete, when the babies are 'stable', and if the obstetrician is finished with suturing her perineum, the woman will be given her child(ren). 'Unstable' babies disappear from her reach and her view—they are taken to intensive care, to be further assessed, monitored, and observed, by someone else.

Women who give birth to twins are often left alone after the birth, to be assessed, and stabilized, and some are left alone to recover from the effects of an epidural or general anaesthetic. A mother's thoughts are with her babies, and what *didn't* happen at the birth: "Like I understand [that they had to be taken away from her], but they still should have shown me."

[17] Only very recently have health professionals introduced 'co-bedding' for twins in the neonatal intensive care unit (personal communication, Dr. P. Byrne, February 15, 1999).

Chapter Eight

Stories of Loss

One does not give birth in pain, one gives birth to pain. . .

Kristeva (1986), p. 167

Sometimes things do "go wrong" at the birth of twins, the "something" so feared by women does happen. In the 'lottery' of twin birth, where the odds of having two healthy babies and a healthy mother are continually calculated by health professionals, some women lose. To lose, to be without something through no fault of one's own, is to be in a situation where one has no hope of recovering that which is lost. One cannot recover gestational time once a premature birth has occurred, or recover the life of a baby that has died. The loss is a deprivation, a suffering, a failing.

In this chapter, I will explore four women's stories of the losses they experienced during twin pregnancy. Some of their losses are obvious, such as the death of one or both twins during pregnancy or at birth, but other losses are less obvious. My dilemma in presenting these stories, in continuing this written conversation in this way, is this: I found the 'twin community' in this area to be very small. By this I mean that many of the women who conversed with me about their experiences know each other through local support groups and multiple birth organizations. Some women know each other's stories as friends, and as supports, and others through 'hearsay.' So, acknowledging that I established consent with each of the women who spoke with me, and that I discussed the issue of anonymity with each woman, I will write these stories of loss in such a way as to protect these womens' anonymity. In cases where I feel that certain information might identify that particular

woman to readers, I either omit it, or if the information is necessary to come to an understanding of her experience, I refer to the information in a more general way (i.e. as a medical condition rather than multiple sclerosis).

Enduring the unexpected, again: Janet

Janet and her husband, Reg, waited "a whole year" to see a physician in a major urban centre. Janet hadn't been having menstrual periods, so she and Reg were sure that this was "part of the problem" in achieving a pregnancy. In the specialist's office, Janet was told that she had polycystic ovaries.

> So he [physician] said, "Do you want to have a baby?" and I said "Yeah", and he said "Do you want to start now?" and I said "Okay", so he gave me Clomid. I think he gave me 50 mg for 5 days and so then I had to take your basal temperature, I did that for a whole month and my temperature went up and down up and down, down. When I went back to see him in the next month he said, "Nope, it didn't work." So then he doubled it. He gave me 100mg for 5 days and I did the same thing again. By about half way through the month I was getting frustrated and my mother-in-law set up an appointment for me to see a Chinese herbalist and I went to see him and we talked about what I wanted. He told me I had to lose weight and you have to eat properly and he gave me a whole bunch of different herbs, well three different herbs, and I think it was a week later that I was pregnant. That's when I conceived.

Janet returned to the physician the next month with her temperature graph.

When he looked at the chart, the physican told Janet that "it worked", she was pregnant, but Janet wanted to have a pregnancy test done rather than trusting the plots on the temperature graph.

> So we did the test and I waited and the nurse comes in and she looks at me and she goes, "Am I supposed to tell you this or is he supposed to tell you?" I don't care, it's going to be negative anyhow. That's all I've had. She said, "It's positive." It's what? You're kidding right?

Nine weeks into her pregnancy, Janet experienced some vaginal spotting. As a result she was to undergo an ultrasound examination. Just before the ultrasound, Janet thought there might be a "problem' with the pregnancy.

> I told her [mother] my pants are getting tight and she says, "Getting tight!" She says, "You're only nine weeks. You shouldn't even be like that unless you're expecting more than one." With the Clomid, I knew there was that chance of having twins, or triplets, or whatever. So when I went over there [for the ultrasound] I was happy. But I wasn't really shocked by it because I kind of had it in my mind that maybe that was what was the whole problem.

Janet was happy about expecting twins. "Like I was really just glowing. I thought, oh this is so neat. So then you think: two of everything." Janet told Reg about the pregnancy by showing him the photograph of the ultrasound examination.

> I took the picture to him and I said, "Well what do you see?" and he says "I don't know. I can't even tell what's on this." I said, "Well there's baby one and there's baby two." And he just smiled, like there's no hesitation, there's no oh no.

Janet's pregnancy was a "good" one. "I never had high blood pressure. I never had the swelling. I never had any of that stuff. I didn't gain a whole lot of weight. I felt good about it. I was excited." She worked until she was 29 weeks pregnant, when she started "huffing and puffing" when she was walking down the halls. It was time to quit work and stay home and rest.

As her pregnancy progressed, Janet's bodily sensations were new and strange to her.

> It was getting harder, harder to get up, harder to move. I found sleeping more uncomfortable. The kids were kicking more, keeping me awake. Nothing fit the way it used to fit. You just felt like a big balloon. You just feel like you're blowing up. Anything bumpy would bother me because they were sitting up so high under my ribs by that time and up against my lungs. I couldn't breathe the way I used to.

She had feelings about what the babies were. A boy was lighter than a girl, a girl was more active than a boy.

> I just had this feeling that it was a girl and a boy. Everything I looked at was for a boy and a girl. It just felt like a boy and a girl. I think it was from the weight and the energy levels of them. The one on my left side was the most curled up and the one on my right side was always stretched right out.

Janet had nine ultrasound examinations during her pregnancy. She found the ultrasound difficult: "Emotionally going in I was scared because you never know if you're going to find something that's wrong." Physically, at the beginning of her pregnancy the ultrasounds were "fine", but as her pregnancy progressed they became

more and more uncomfortable. When she was lying down to be examined, she found the weight of the babies, pressing down on her, "suffocating". Because of the ultrasounds, she "knew her children before they were even born". Every three weeks she was reassured that they were developing properly: "I felt like I knew almost what they looked like. I knew that they had all of their arms and legs and toes and I knew they were healthy at that point." Janet didn't know the sex of the babies before the birth, and she didn't want to know. By having a surprise, she would make the birth "even more exciting at the end".

In preparation for the birth of her twins, Janet attended prenatal classes with her husband. She read books. She "thought a lot about what was going to happen". And she thought about the pain. If she could prepare herself for the pain, she felt that she could "make it through" the labor and birth.

Janet was "hit" with her first contraction while buying clothes for her husband at a local shopping mall. She didn't recognize this pain. It confused her.

> It's almost like a squeezing in my lower abdomen, lower down. I remember standing there going "Oh I never felt that before". We did more shopping and I never felt quite right. Like I always had this lower pain in my abdomen. I didn't feel like myself. I felt like this isn't right. So then it was supper time and I couldn't sit still. I couldn't sit in the chair. Like I'd get this pain and I had to stand up.

Early the next morning Janet went to the hospital. She was admitted to a birthing room and attached to two fetal monitors and one monitor to assess her contractions. "I had a hard time laying in the bed because my back hurt so bad. I

wanted to walk." Because she was in "early labor", Janet was able to get up and walk. She walked most of the night, and most of the next morning. She was put on "a drip" to augment her labor, and a physician artificially ruptured the membranes surrounding the babies in order that her labor would progress more quickly.

> One of the interns came in and he tried rupturing my membranes. At that point I was still only 3 centimeters dilated and it hurt. It really hurt. I don't know how come it hurt, but I remember looking at my husband saying "Get this guy out of here" because it's hurting me, and of course you're contracting on top of all of this while he's fiddling around in there. It took him a long time to rupture the membranes but then he eventually did get them ruptured and then as soon as they ruptured, they [contractions] were one on top of each other, just instantly. . . . Man, I remember being in so much pain. I sat in the shower about three times. Finally I could barely walk to get back to the bed and then I was screaming , "Get that guy in here with the epidural because I can't handle this anymore." I think I waited too long because I tried to breathe through it and tried to do it naturally but with the oxytocin drip going I think it was too much. It hit me all too fast. I think if I could've gone through it naturally on my own, then I think I could've dealt with it a lot better than just having it happen all at once.
>
> The anaesthesiologist came to administer an epidural block to Janet.
>
> . . . and that was the hardest thing I've ever had to do because you can't move and I'm contracting on top of all of this and when I'm contracting I'm moving. So I'm trying not to move and I'm crying, and then I'm contracting

and I'm crying because of that. Then they finally got the epidural in and that working and they laid me back down and then I just shook. I just sat there and shook. It was almost like a shock. Like my body almost went into shock. I had no more pain but it was, I just sat and shook like I was cold.

Janet's epidural worked for a little while and then it began to "come out". She was feeling the contractions again, and feeling the urge to push. When she told the nurse that she had to push, she was told not to push yet. After the physician checked her cervix to see if it was fully dilated, things around Janet changed quickly.

Then it was just a mad rush of moving things and detaching me from the things, all the IVs and stuff. They had to take me from the birthing room, around the corner down the hall around the corner into the delivery room.

In the delivery room, Janet was told she could push. Her daughter was born first, and five minutes later a son was born. "I don't remember having any pain . . . ." Janet saw her daughter and her son only briefly. When she was looking at her son who was in the arms of a nurse, Janet realized that something was wrong.

Dr. X started hollering for a cross matching of my blood and to get another doctor and another resident in there. After the placenta was delivered that's when they noticed that there was more of a problem than they thought. They knew that I was starting to hemorrhage really bad. Right about then all modesty is shot through the roof. You have nothing left by that time when you have four people down there trying to stop bleeding. Because I do work in the medical field, it was almost worse for me because I knew what they were talking about. I knew what was going on. I sat and listened to them. I knew

what was happening. They were really good about it because they sat and told me what was happening. The chief resident, she said to me, "Your uterus isn't contracting down. We are having a hard time stopping the bleeding." At that point I was starting to get worried. Then they started putting another IV in my other arm, and they were trying to get more different drugs to try and get the uterus to contract down. They were trying to suture up a rip in my vagina wall. . . . By 8 o'clock, which was one half hour after my second one was born I had lost, what did they say, approximately two and a half liters of blood. At that point he [physician] says, "We have to take you in and find out what's happening. You've lost too much blood already." So they started moving me at that point and I remember laying on the bed thinking I'm going to pass out. I can feel myself going to pass out. I remember feeling scared. I remember saying, "I don't know what's going to happen. I'm scared."

Janet's physician told her that they would try to "save her uterus" but if her condition was life threatening, her uterus would have to be "taken". "At that point you just think, well do whatever you have to do." All of a sudden time was important to Janet.

I remember, it was eight o'clock. I remember looking at the clock when I went into the OR. I remember thinking, Lord, just get me through this. Just let me wake up. That's all I remember saying. I swore I wasn't going to pass out until he had that mask on my face to put me under.

Three hours later, Janet woke up in the recovery room. Her physician was there. The first thing he told her was that her uterus was gone. She was immobile,

attached to monitors and IVs, bandaged, and groggy. In surgery, they had found a tear in Janet's vaginal wall, and a tear in her cervix, one that went up into the back of her uterus. She had received nine units of blood and five units of platelets.

> At that point I didn't have a clue what had gone on. I didn't know anything that happened. All I knew was that he had done a hysterectomy on me and I was still alive. That's all I knew. I remember my husband crying . . .

The next afternoon Janet wanted to be taken to see her children in the Neonatal Intensive Care Unit. She didn't remember seeing her son the night before.

> I remember looking at him. The first thing I said was, "Look at the size of the feet on that kid." Big feet. But I remember thinking I can't lay around. I've got to get off this bed. I've got to get moving or I'm not going to be able to look after these children . . . . I remember the feeling of gee I missed out on something here because I had the surgery. I didn't get to hold them right away. I didn't get to nurse them right away.

Three days after the birth, Janet was forcing herself to get up and move, so she could take care of her children. But she had physical problems of her own.

> By the third day they had taken out the epidural and the IVs and the other stuff, so I could get up and walk around. I was still very puffy. I was still very pale, still very weak. I felt very dizzy when I got up and walked. I had two JP drains so to walk to the bathroom you'd hold everything and try to get to the door. I had staples so it was sore to bend, sore to stand up. I swelled at my feet. They were just like balloons. They swelled right up. I felt like a bear.

Think of the big feet and the claws that stuck up. I felt like a bear, grizzly bear's feet.

When she felt better physically, Janet began to think of how this birth experience had changed her, and had changed those around her.

I think by about the fourth or fifth day my husband and I were sitting there. Then the tears came and the actual realization of what actually happened and how close I had come to death and how close they were to losing me. . . . I didn't realize how he felt about almost losing me. It really bothered him. It bothers me now to this point, to this day, that I actually wasn't . . . I almost wasn't there to raise my own children. You think, man it was too close. It was actually too close. It took me five days to realize what actually happened was that bad . . . . The emotion of afterwards and thinking back to all of what happened just devastated me to the point where I just couldn't believe that I almost wasn't here to raise my children. I almost missed all of this and to this day I still think of that when I look at them. I almost missed seeing them. But I think it's made a difference to my husband and I in the way we relate, because he knows that he almost lost me too. He's a lot different than he was. He doesn't take everything for granted anymore. I don't take things for granted. I don't take life for granted, and I think having a boy and a girl, [it] was much easier to accept the fact that I wouldn't have any more kids.

Janet's twins are four months old now. Looking back, she feels that she has had little power regarding her own childbearing—when she wanted to become pregnant, she didn't; when she wanted to have one child, she had two; when she

wanted the choice to have more children, that choice was removed. Everything that she expected to happen did not happen.

> I think it still bothers me at times that I never had that choice. Never had the choice that I didn't want kids anymore. It was made for me. But yet I know that not being able to have the children and having my hysterectomy—I mean there was no other way. So I dealt with that. It bothered me when I couldn't get pregnant on my own. So when I had to go on the fertility drugs, I had a lot of mixed reaction from other people which made me think, I guess it made me feel less of a woman because I couldn't do it on my own.

Losing the certainty of outcome and future: Olivia

Olivia had struggled all of her life with a chronic illness. Because of her illness, she and her husband had difficulty achieving a pregnancy. "We tried and tried. We went through all the testing. Everything came back, and it was unexplained. They couldn't figure out why. I was fine. He was fine." They sought advice from an "infertility specialist", who enrolled Olivia into a research study. She took a "new drug", was artificially inseminated, and "it worked".

> The good news was that yes we were pregnant. The bad news was there was multiples. He didn't know how many. The first ultrasound that he could do was in five weeks so I would've been seven weeks pregnant. So for five weeks we sat around thinking okay is it one, is it two, is it five?

Because of her illness Olivia's pregnancy was risky for both her babies and herself. With a multiple pregnancy, she said, "high risk was written all over my forehead." She was "nervous", "excited", but she and her husband, Paul, decided "to

hold off in telling everyone" for awhile. Twelve weeks into her pregnancy, Olivia visited the hospital emergency department for the first time.

> I was still working and I passed a blood clot and I went in to Emergency in the ambulance. I sat in Emergency for four hours not knowing what's happening, nobody telling me anything. It took two hours to even see a doctor, anybody that even came for me. He did an exam and he didn't even say anything to us. Like he didn't even give us a clue what was happening. We didn't know. I was scared. He had written something up on the computer and he'd left the room and he didn't shut off the computer screen. He had written on there 'inevitable miscarriage'. So for the next two hours we sat there thinking oh my God, we lost the babies and nobody cares. What's happening? There was nobody around to ask. We asked the nurses you know, "When is the doctor coming back?" "Oh he's busy, blah, blah, blah." So for two hours we were thinking we lost the babies.

The next morning, Olivia went for an ultrasound examination. She found that the babies were "still there". Olivia was instructed "to stay home from work and do as little as possible". She followed her physician's directions. Her pregnancy was "like a ball of what ifs". With her own disease complicating her pregnancy, she knew what could happen. Olivia's time of pregnancy took on a different meaning.

> I couldn't just stay still and take this ten minutes for what it was worth. Always kind of looking forward. Time just didn't—I don't know. I just tried to strive to get through the day. If I could get through today I could make it through tomorrow.

Twenty weeks into her pregnancy, Olivia was put on bed rest at home. "I wasn't allowed to do anything. I was basically allowed to get up and have a shower and eat and that was it." She had great difficulty following this regime. She was "getting very stressed, anxious".

> When I was just over 25 weeks [pregnant] I woke up in the morning and I had extreme, extreme cramps that came. Like I couldn't figure out what was happening and the whole week prior to this I had had major back pain. My doctor at that point figured it was a sciatic nerve, a pinched nerve.

Olivia phoned the hospital, and was told to come in. When she arrived in the labor and delivery room, her cervix was dilated and she was having contractions. She was given medications to stop her labor.

> I was sick. The room, all of a sudden—I didn't realize that they had actually started the drug. I just thought that this part of this delivery, kind of thing you know, I was feeling a little bit woozy. I felt sick to my stomach like I was going to puke, and I didn't puke it kind of stayed back. It was gross but once that kind of wore off they gave me some Gravol and I felt a little better. It's gross, it's just a sick drug.[18]

Olivia was placed on complete bed rest—she was unable to get out of bed at all or even allowed to sit up.

> I was worried, really worried at that point because I had read all my books and usually before 24/25 weeks they [twins] just don't have that much of a survival rate and if they do they're pretty sick, really sick. So every day w[illegible]

have the doctors coming in and telling us all the different possibilities and if the baby is under this much weight what would happen, if it was over this much weight what would happen. So they sent me for an ultrasound and the technician told me that the babies—I had two 2 1/2 pound babies and when I came back up to my room my doctor had come in and saw me and he said, "You'll be lucky if you have two children." And he said, "There's no way they will survive so many weeks along, good luck." But it was the way he told me that. There was just no sense. Like this is what's going to happen and too bad. Too bad, so sad.

With this news, Olivia felt "lousy", and began to question her own actions. What had she done to cause this?

Maybe it was my own doing by not doing the bed rest at home, like I was told, or the worrying. I don't know. I was really worried. I didn't know what to expect. I didn't know what our future was going to be.

In the hospital, Olivia rigidly adhered to her physician's orders about bed rest. Two days later, her own disease complicated her pregnancy situation. "At that point it was me or the babies." They stopped all of her medications and she soon was in labor. Throughout her pregnancy, because of her illness, her high risk status, and her twins, Olivia had prepared herself for a surgical birth. She received an epidural, "very painful, never again", and a caesarean section was done.

I ended up having a two and a half pound baby and a two pound, one ounce baby. What really scared me was me and Paul was being able to see what was

[18] The drug she was given was Magnesium Sulphate.

going on because I was awake. What really scared me—like you see in the movies all the time that it's a boy, or it's a girl. You know you get to hug and kiss and all those fun things. I didn't get to hear them cry. I didn't get to see them. I knew what they were because Paul told me and the guy behind me told me what they were but I didn't get to see them and not knowing I think was my biggest fear. But yes they were all right and yes they were really here. That's what upset me I think the most in my whole pregnancy was not seeing them after the birth.

Groggy, ill, and in pain, in the night following the birth, Olivia had not seen her sons, yet was asked to give consent for surgery on one of them.

I was scared because I didn't know what was going on. I didn't know if he was going to make it. They just said it was serious and you know that he needed it kind of thing. Well, explain to me more, and from what I remember nothing was really explained to me very well. It was just kind of here, here's this paper, sign. But Paul did the signing and what not. I was scared, very scared, not knowing. It's the not knowing that scared me the most. I did not know what to expect. I had asked for pictures, you know, bring me pictures. "Oh the nurses are working hard." And they can't take five seconds and take a damn picture. I want to know if my babies are okay. Yes, Paul had been there and he had told me he saw them but for me to see it myself. I needed to know. [Seeing them would have] made me feel better knowing he was okay and not—I mean I know he wasn't okay. I know he was a very sick little baby but I just think seeing for myself would've just done it. Just reassured me that he

was okay, this is what happened. That I has some control over the situation through this. That would be the biggest thing. I felt like I had no control and I didn't have any control. The doctors have control. The nurses have control, not me.

As soon as she could sit up, Olivia went to see her babies in the Neonatal Intensive Care Unit.

All I could see from sitting where I was, was an open bed warmer with half of the baby and tubes. I was just sick to my stomach walking into that NICU of babies that I could see. I couldn't see mine because I couldn't get up but even the bigger babies, they were a little bit more healthier and what not just made me sick . . . . It wasn't really until I actually got to stand up that it was a realization of what we were in for. What was really happening and how sick the boys were . . . . I really just saw two very little bodies. There was no life to them. Andrew was totally black and blue from the delivery. He didn't even look like a baby. He just looked like this little body, like an alien body was all I saw. You know his big head and his long legs. Lifeless little bodies is what I saw and that the machines were doing the breathing for them. They weren't babies, they were a piece of machinery. They were a test to see what we can do for these boys is what it felt like to me. Like they didn't feel like they were mine.

Olivia and her husband went home alone after the birth of their twins.

When I was in the hospital you know and you see all these women be with their babies and when it came to the day that I left, I left with all my flowers. I

didn't leave with car seats. It made me very sick to my stomach knowing that I had to leave my babies and not be able to take them with me. It was very hard to deal with. I didn't know how to deal with it. I didn't want to open up to anyone else, to talk to anyone else. I didn't know who to talk to.

Olivia was "without" Andrew for three months and "without" James for five months.

I don't know which would be harder actually—coming home with one baby or coming home with both. Usually you know when you get to leave the NICU, you get to leave it. You don't have to come back. I left it and I had to come back and face the reality every day for two months until James came home with Andrew at home. Knowing I had to keep myself up for the baby that was at home as well as you know giving my love to another baby that's not at home with me. Trying to still be able to bond with the baby that I didn't have yet.

It was during the months in NICU that Olivia's "aliens" became "babies". We watched them, were able to fight for them, get through these surgeries, when they could open up their eyes. They couldn't really acknowledge you. They didn't know who you were, but they would react to your touch. They would react to your voice. When they reacted to me and to Paul was when I really felt like they were ours. Like I said they couldn't see you and know who you are, but I think they do. I think they know who mom and dad are, kind of from voices that are saying, you know, like in utero that they acknowledge you but just basically when they react. Li[illegible] when you'd put your finger out,

not grab it, but the reflex was kind of there to hold it. That's I think when they became my babies. And when I placed a name to them. They didn't have names for three days. They were Baby A and Baby B for three days. No names and I think that was another reality of when they were mine. Up until that point actually I hadn't even cried from the time they were born until we gave them a name. Like I said that was because I realized that they were really mine, not somebody else's, mine. I bawled. I just bawled for days after that point.

Looking back, Olivia's pregnancy was "too short lived to really get into it". Short, and complicated with her own illness, it was a pregnancy that she could not have imagined.

Most people have eight or nine months, and I had five and a half. I was just getting to the point where I was starting to feel things. Feel the bones. I didn't get the butterflies. I didn't have the morning sickness. It was like I wasn't even pregnant except for this big bulge. Stretch marks to go with it. I don't know. I was numb when I was pregnant. I was numb to everything you know.

But even in her numbness, Olivia felt "attached" to her babies, physically and mentally. Attaching meant hanging on to her pregnancy. "It was something that I so desperately wanted. Like I said it was my God-given right to have a baby and I was going to have this baby, but . . ."

Olivia had desired only one child. With one baby, she could have faced a pregnancy complicated only by her own illness. With a twin pregnancy, she faced her own physical difficulties, a pregnancy and birth whose course she could not chart, and

the idea that she may have been the instrument of her own children's prematurity and illnesses. Andrew and James are now just under a year old. Their first year of life has been a litany of hospital admissions, surgery, and illness. Olivia still faces possible developmental delays, and other complications associated with extreme prematurity. And daily, she faces the spectre of her own early death.

Facing birth and death: Angie

Angie's "drugstore bought" pregnancy test was positive. She was pregnant for the second time. Within a week or two of the positive test she was feeling "awful". Nothing relieved her nausea. Eight weeks into her pregnancy, Angie and her husband Nick went for an ultrasound appointment and heard the words, 'You are having twins'. "I wasn't thrilled when we left. He was excited and I was just like, how can this be happening?" Physically, Angie felt worse. She "didn't think she could handle twins".

> Every day was just a struggle to get through. Can I get to tonight when I can go to bed and go to sleep and not feel like this anymore? It didn't matter what I ate or anything. I just got sick all the time. I think that really didn't help because I was thinking ahead, thinking what if I never feel better than this and then I have two of them to take care of plus another little one?

In preparation for the new additions to their household, Angie and Nick bought a bigger home, and made financial plans so Angie could leave work earlier than she had at first anticipated. They hesitated to tell anyone that they were expecting twins. Angie said she was "just [being] cautious".

I just wanted to wait and see how everything was going. You know it was so hard to believe that it was happening, that every time you'd go to the doctor it was like, how's everything and does everything sound okay and all this stuff?

In her twenty-fourth week of pregnancy, Angie went for her regular pre-natal check at her physician's office. Nothing seemed out of the ordinary in the physician's examination, but Angie left the office with a feeling that something might be wrong.

They always listen to the heartbeat and for some reason that day he couldn't pick up a heartbeat on the one side. I thought that's strange because I've wondered, like I had this feeling about—I was always saying that the one on this side I think is this sex for some reason, and I'm not sure about the other one. I just didn't know. I was starting to feel movement on the one side but not as much, or it just wasn't the same on the other side. So when I went to this appointment and he picked up the one heartbeat and he said he heard the other one too. I thought okay, but I remember coming home and thinking you know I told my husband "It really bugs me that I couldn't hear it," because there was never a time with my other pregnancy that I couldn't hear the heartbeat. But the doctor said that it was there, and you know sometimes it just depends the way things are lying and that kind of thing . . .

It was time for Angie to tell her colleagues at work that she was expecting twins and that she would be leaving work earlier. She did tell others, but in her telling, she tried to find out about the sensations she was feeling.

I said "I don't know, I think it's kind of strange that I'm not sure if I'm just feeling one or if I'm feeling two, so it's hard to know if everything is okay". . .

. When you think back you think how strange that I would comment on stuff like that but for some reason it worried me the whole month. Then I guess I heard some strange stories in the same month which wasn't great. The day I told my boss, he said "I'm really excited for you but I got kind of a different story to tell." They had some friends in their family whose daughter was expecting twins and then we just found out that she lost one. He kind of went into some detail about the story but I thought isn't that a strange story. He said, "Not that that is going to happen to you but that's the only twin kind of story that I know and it didn't turn out to be a good one but anyway the girl is now just expecting the one baby." I thought, well that's really strange.

Angie heard more and more stories about twins and twin pregnancy over the next month. By the time Angie went for her next ultrasound, her fears began to crystallize.

So we went for this ultrasound and she took a long time looking at me but with twins they do, and I kept asking her "Is everything okay? Are all of their little arms and legs there?" And I asked her at the end of the exam and she was making all of her notes and she didn't answer it and I thought, well okay, that's not unusual. They like the radiologist or whatever to come in and tell you it. She said, "I'll go get the doctor and I'll get your husband to come in." She went out and she was gone for a long time and you know, even then I just thought there is something wrong. I'm not imagining this. She came back in and my husband came in and the doctor came in and he did a scan and he said, "You know you might have guessed this by the amount of time she was out

but there is a problem." At that time you don't know whether to—that's just like your worst nightmare . . . From what we can see the problems are significant to the point that this baby won't be, I think he said, compatible with life, is how he put it. He said the baby is alive. We can see from the scan here but if it goes to term you know they weren't certain, but if it goes to term it wouldn't survive once it was born.

One of their twins would die. Angie and Nick's "worst nightmare" had happened. They were sent to a specialist for more tests. The news about their baby was told to them over and over. Both Angie and Nick began to see a positive aspect of their bad news.

I guess the good news is—I don't know if this sounds selfish or whatever—but at least they didn't give us something in between. They didn't kind of say, well you know there's some really really big problems here but you know with enough intervention and enough tubes and hoses and wires. You know, something like that. That would have been the worst case scenario for us really. So of the alternatives we had to say this isn't so bad. At least it's not something that we have to make a decision about. The decision is made. There will be nothing we can do. So I think in some ways that made it easier.

What made it harder is feeling the life of the baby that Angie knew she was going to lose.

So now we had to somehow focus our efforts on the baby that's okay, while still knowing that I am carrying and I am feeling the other baby kick for another 4-4 ½ months and that makes it a lot harder I think.

Angie and Nick did not have the choice of "ending" the pregnancy, grieving, and getting on with their lives. "With one perfectly healthy baby in there," they said to each other, "There's just nothing that we can do about it." At their next ultrasound appointment, they questioned whether it was a "genetic thing", but the baby's condition was associated with a problem during its development. Knowing this, it was easier for Angie to go on. She knew what the birth outcome would be.

> If the baby actually lives to term we could struggle for a few days to try and keep it alive but it won't—it would be major, major work and it won't make it. And it was so black and white, which was not great, but a lot better than something in between. So I think from then on it just started to get a little bit easier because we just knew that there just wasn't anything that we can do, and it will be day to day to see how long the baby goes.
>
> Angie worried about the baby.
>
> Quite frankly I guess the thing that woke me up at night worrying is if the baby did go to term, what was going to happen when it was born, and was it going to suffer? . . . You know because it could not make it to term, or it could live. I don't know, was it going to live an hour? Was it going to live fifteen minutes or was it going to live three days? Like we just didn't know and they didn't know even.
>
> But the baby did not live that long.
>
> On the [exact date], I went for an ultrasound and even then I was driving there and I thought today they're going to tell me that the baby didn't make it. I went there and at the end of the appointment, although the girl doing the scan

didn't say anything the whole time, but then the doctor came in and she just very casually said, "Well you know the one baby looks good. It's growing good and everything and we couldn't pick up the heart beat on the second baby, on the twin that is having the problems." And I just wasn't surprised. Like I thought, I just knew that coming here today it at is was over . . . . I don't know why, I just had a feeling that I hadn't felt a whole lot of movement in the last couple of days. I wasn't sure, I mean sometimes they have quiet days or whatever. But it just dawned on me as I was driving there. Today is going to be the day they tell me that it didn't make it. And she did, and it was hard. I was upset, and I apologized to the doctor at the time. I said, "We knew this was going to happen and this is better than some of the other alternatives for when this will happen but it's just hard to hear it."

In a way, Angie felt better. She knew that at least a part of the unknown had become the known. She knew that her baby had died, and she had got through that part. What she faced next was the birth.

I don't know what's going to happen when the actual delivery comes. I don't know—I can't really envision it all, but the doctors are pretty relaxed about it all you know. So it's just going to be, provided not a whole lot changes with the condition of the other one, it will just be a regular delivery.

And while she waited for the birth, Angie carried one live child and one dead child in her body. She received regular steroid injections in case her body decided that labor should begin. She stayed on bed rest at home, juggling child care for her toddler. "I really, really feel as if I'm just carrying one. I don't know when the

transition happened. I think probably after we found out that the other baby hadn't made it." She thought about the birth, but tried not to think of it. "Sometimes we talk about that, we kind of say, gees what's going to really happen there? It's better to just not think about it." But the thoughts keep coming back.

> I wonder, you know, if they'll be able to clean everything out. Why this should upset me I don't know . . . . I kind of wonder, will we see the baby? I don't know . . . . I kind of want to. I'm not sure.

Angie thinks of her live baby as a singleton, but her family speaks of her twins. She worries that there was some special bond between the two babies before one died. She wonders: Do babies forget what happens to them in utero? Do twins have a bond because everyone treats them as if they should, or was that bond really formed before birth?

When Angie and Nick went into the hospital for the birth, eleven weeks had passed since their baby had died. Angie thought that they had enough time to come to terms with what had happened to them. Angie birthed a healthy baby girl. While she was holding her new daughter, one push birthed the placenta and her dead baby. Angie had decided that when the birth came, she would know what to do about her dead baby.

> I wasn't sure and after the babies were born it just didn't bother me at all to see the other baby. I think we had come so much to terms with it that it was good to see it. I wish we would've known what the sex was so we could have—it just would have made it that much more, I don't want to say personal

because it was personal, but real or something. It's just strange not to know whether it was a boy or a girl.

When Angie became pregnant, she expected one child. Then she expected two. She never expected to lose one child, while the other lived, or to have to rejoice and grieve at the same time. Do life and death at birth negate something, as if one cancelled the other out?

You know we think it's particularly hard because we had two and we couldn't deal with the one loss and grieve and get over that and move on because we still had to focus on the baby that was okay. But on the other hand if I would look at it from another perspective, as least we have the one . . . . So it's a real mixed bag of emotions.

Brief Lives: Des

At 28 weeks into her first pregnancy, a pregnancy achieved through assisted conception as a subject in a research study, Des didn't feel well. She began to experience vaginal bleeding, couldn't get comfortable sitting, and thought she was constipated. She went to her physician, who sent her for an ultrasound examination. Des went for her appointment, but someone else who needed the ultrasound "more" was put into her appointment time. Des was sent home to come back the next day. "I'm bleeding, and I'm having rectal pressure and back pain, and I'm very uncomfortable but come again tomorrow!" Des went home and tried to get comfortable, but couldn't. That evening, she went to the hospital and demanded an enema. "I can't even sit. I can't stand. There's nothing I can do. I'm just absolutely mental. I'm a mental case now," she told the nurse. Before the nurse administered the

enema to Des, she did a vaginal examination to check cervical dilation. She found Des's cervix to be ten centimeters dilated. Des had already progressed through the first stage of labor. "The next thing you know I'm waiting for the anaesthesiologist to have a [caesarean] section and that was it." Des was told that she must have a surgical birth. Because she had not had the ultrasound, the gestational age of the "baby" was thought to be 24 weeks. She was told that at 24 weeks, a surgical birth was "best for the baby". Gary, Des's husband, was still at work. "So they did a section and they woke me up and said, 'You just had twins'." Des and Gary had been expecting a single child. They now had 'undiagnosed twins'.

> I wasn't prepared for one at that point yet, and then when they said two, all I could think of was all the things that I needed to get. That's the first thing I thought of. Just shock. I went into shock for a few days.

When Des awakened from her general anaesthetic and was told that she had birthed twins, her first thought was to see her babies.

> They wheeled me by without my glasses but I was on morphine. I couldn't remember it. It could have been anybody's baby. There was no connection there.

The next morning, Des was transferred to another hospital with her babies. Her babies were not "doing well".

> The first meeting, when I went up to see them, there was about ten people around Susanne's isolette and I was in a wheelchair and I was just in a fog. I think they had just only like maybe an hour before given me another morphine shot. Then they asked me if I wanted the baby baptized and I said yes and they

asked me if I wanted to hold the baby and I said no. Then they said, "Well we think you should." Then I was really happy after thinking that well why did I say no but I just wasn't thinking you know. Then I think they showed me Gina. Anyway I just remember my sister was with me and she was hyperventilating because she was in the NICU and she can't handle that kind of stuff and the social worker was helping my sister. And I was just like this—just feeling like this was an out of body experience. I can't believe this is happening. What's going on, you know. Just all those things going through my brain. And then Susanne died right around the time that I was sitting there. She had died. And she was dying when they gave her to me at that point because they couldn't revive her anymore. But I don't really remember it very much. You know and Gary wasn't there. He was there until nine o'clock in the morning. He just went home, then Susanne died.

Weighing slightly less that one pound, Susanne lived for only twelve hours. Des saw her only twice, and held her only once.

I was very aware of what was going on but that time it was like I could've had morphine for a week if that's what I wanted. It's almost like they were compensating for what I was going through in a way . . . . You know one baby was dying and the other one wasn't looking very good. If I was in a little bit of pain it was just, yeah, here's some morphine. It just seemed so available.

Gina was still very ill. Her condition was complicated by a genetic defect. Recuperating from her own surgery, Des's realization that she was a mother, a mother of twins, a mother of a child who had died, and a mother of a child who was

ill did not come easily or quickly. "I really didn't know what was going on. It just happened so fast. So much. Doctors talking to you. Nurses talking to you. You just can't absorb it all. It's like you're not there, you know."

> Probably three or four days after Susanne's death--of course the hope was all on Gina, and we were sort of still in the honeymoon phase—you know that's how I think of it. That you're not really—reality isn't completely registering for Gina. We were dealing with Susanne and planning her funeral, and then I started grieving it, and crying and being more emotional, like feeling it. Whereas the first few days I didn't know what to feel. I was numb. And then Gary and I had Susanne's funeral, just a quiet one with him and I, and then we focused on Gina. And it was still a little numbing, up until and even after Susanne's funeral. It was kind of numbing a little bit I guess. But very emotional, just really emotional, ups and downs and ups and downs and ups and downs.

Des and Gary concentrated their efforts with Gina but she remained in very serious condition. As Des and Gary came to the realization that Gina was a very sick baby, they "hit another brick wall".

> It felt like Gina had died and then we were reliving—she had died and then we were getting to know Gina again as a different baby because she wasn't the one that we knew. You know how you make future plans, you dream. Well, Gina, the first baby, died in our minds, and then we had to get used to that idea. It probably took us two or three weeks to say, okay, this is the way it is. We're going to make it through it and then it just seemed to me, a few weeks

after they told us about the [genetic problem] and the [physical problem] and everything. She wasn't getting any better. She was just like the Pillsbury dough boy but only ten times larger.

Des held Gina only once, when she was about a month old. "We could just hold her hand, touch her, stand there, sit there, but we couldn't—I held her, around Mother's Day I held her." As they watched their daughter, day after day, they began to question, why?

Everyday I would look at her and think what are you guys doing? What's going to be left of her when you guys are finished? I thought, okay, enough is enough. She was never coming off. It didn't seem like she'd ever get off the respirator and she never did, and I wanted them to stop it. I had had enough. That's enough. Just stop it. If she's going to live, let her live on her own. Just stop all this stuff. It just seemed relentless to me. But they still went to the ethics committee and the whole nine yards and they even let us meet with the ethics committee. I told them what I thought and they said, "No Gina is in a grey area. So until she gets in the black or the white we're just going to continue." So about a week later, maybe ten days, they said,' It's enough," and they finally let her go. That was another depressing, depressing, depressing time.

Des got to hold her "finally, finally, when they finally said 'yeah, we're going to take her off the respirator' ".

I got to dress her and hold her because I was so angry at the doctors and the nurses. I was just angry at the situation but I was angry at them for what they

were doing to her you know. I felt like they thought because she had [genetic problem], that's why I wanted to let her go but you know it's just enough to watch your flesh and blood go through that. Anyway we got to hold her for probably an hour. She just turned—they took her off that respirator and she was as blue as blue can be, purple. She could not oxygenate one little bit. She was just so sick. Anyway we had a funeral and invited all the relatives and everything but it was hard. It was hard partly because with family and stuff they thought, well she had [genetic problem] so it was a good thing she died. I think that's—you know a lot of people kind of said that in many different ways over the years. I never really felt that way.

Eight years later, Des and Gary's second pregnancy resulted in the birth of identical twin boys. They "got through" it. "I just wanted it to be good. If I was only allowed to be pregnant once then I wanted them to be alive. I didn't want to go through what I went through. So basically [I was] just scared, scared, scared."

I would break it [the pregnancy] down into months. I wasn't going to get excited until after the third month. So after twelve weeks I'm not going to fantasize too much about the babies. I'm just going to get through these next three months because I could miscarry at any time. I mean I was still fantasizing, I was still planning. I had the room all planned in my brain. I can't say that I wasn't but I was trying not to invest my whole self into the pregnancy quite yet. Once I got over three months, okay another three months, I'm not going to miscarry. I guess I could have, but that's how I did it in my mind. Then the next hurdle was 28 weeks because that's when I went into

labor. So then I got 28 weeks and then I was just scared the whole way through. I counted the weeks down. When they got to the age of viability, then I knew that they could survive but their chances aren't that great, then I was really scared. If I miscarried at three months, well that's the way it is, right? But then if it was 26 weeks and I went into preterm labor, well they're going to—you know technology the way it is—they could come out well or they could, you know, all the things I know. So I wanted to get past 30 weeks . . . . Every week that went by was just another feather in my cap and I felt a little bit better.

Even though she felt guilty about using health services, when Des felt any kind of uterine contractions, she went to the hospital.

They said it was just your body practicing, or what not. Anyway I was just, I felt like I was paranoid, but I couldn't relax about it. I just felt like I could go into labor at any time and if I don't go into the hospital and find out, and then I would kick myself. I would get so angry with myself that I didn't get checked out and if something happened and I let it go and I said, 'oh it's okay', and then if something did go wrong then I would be very very upset that I didn't go to the hospital.

During her second pregnancy, Des had twenty ultrasounds.

I thought it was really neat. I mean it was like an appointment every few weeks or whatever the case was, to like sort of visit them in a way. Gary would come every time and we would have a good peek at that time. Just see their little legs and sometimes we would see them sucking their thumbs. I

really liked it because it really put me at ease. When I would go to the doctor and I would tell him all my worries and I was really fixated like I say on my abdomen. I always felt a sense of relief.

This time, Des carried her twins until 36 weeks. Her "water broke" at home. She went to the hospital for a surgical birth, but this time she was awake.

I remember I had my glasses but I forgot to ask for them so I could see them but it was kind of blurry. I just kept asking Gary. "Are they okay? Are they normal? Are they normal? Are they okay?" He kept assuring me, "Yes, they are, they are. Look at them, look really close." I remember even saying things like "Are their ears lower than their mouth?" You know things like that. He just kept saying, "They're completely normal." The fear of something going wrong was right up until the last, until they came out of me. I wouldn't really relax until I could see them.

After her surgery was over, Des wanted to be with her babies. In the operating room, she saw them "only at a distance and then they just whisked them off and then I had to wait until my feeling came back before I could see them". Des had her babies in the evening. By the time her anaesthetic had worn off, it was the middle of the night. "Well it was like being awake, like waiting for Santa Claus. That's what it felt like. Like at 3 o'clock in the morning, get me in a wheelchair, and get me to the NICU now. I cannot take this anymore."

I thought this is just torture, so finally the nurse begrudgingly took me up there and as soon as I entered that NICU it was like entering 19XX. Here I am all dazed and confused . . . . You know coming out of a section and everything

and it just hit me again. I saw Matt first, the little one. Crying, crying, and crying. The nurses are all looking at me. I felt they were. You know there's lots of people around and I'm all emotional, and I'm holding Matt and I'm crying and worrying about Chris who is on A side, because I knew that was not a good thing to be on A side. So it kind of hit me again, just kind of being in the NICU. Knowing that they were there was one thing. But then actually entering it, the noises and the smells, and everything hit me again.

Des wanted to connect with her babies right away.

Who do I go to first? Of course Matt was the most obvious because he was not as sick right? He was my first along the way and I could hold him. It was like I connected first with Matt because I could hold him. It wasn't until later I connected with Chris because I couldn't connect with him until I could actually hold him. Again he was laying there. They had paralysed him. They were putting in a catheter, putting him on a respirator and then they were talking about that he might have a pneumothorax. It all started again. All the doctor had to do was start talking to me and he might have been saying 'not life threatening' but it was like he was saying it was 'life threatening'.

When I held Matt, he looked at me. I was looking him in the eye and he's looking at me in the eye, and we're examining each other in a way. We're meeting each other. So I remember that moment, that first hello. Then when I went over to Chris' side, he's not awake. I could talk to him and touch him but I mean I could've been anybody I felt. Like I didn't know if he knew his mom

yet, you know, whereas with Matt I had that. I could talk to him and hold him and connect with him . . . . Chris, he was just laying there—he couldn't because he was so sick. It wasn't until he started coming out of it and came off the respirator that I was holding him and breastfeeding him and feeling like he's mine. Whereas before that I knew he was mine but I never had that. I really think it's important that when they take them [babies] out of you that they give them to you for a few minutes and not separate you for like how many hours? . . . Like I remember the first moment with Matt, that very first moment. I remember that. I'll never forget that but I don't remember that first moment with Chris because there was 5 or 6 days of worrying and standing at his isolette but not being able to hold him or do anything or make a difference for him because he was just paralysed and drugged. Like unconscious basically. I mean I know the moment with Matt. I remember that. I mean now there is no difference. I don't feel like that moment makes any difference now but in the beginning I felt more connected to Matt than I did with Chris because of that . . . . When we would go to the hospital, we would go see Matt. He's okay. He's in an open isolette so we could do everything for him. I could breastfeed him and then we would go over to see Chris. Well there wasn't a whole lot I could do there. So I felt that was the dark side. This is the good side. I just felt completely different when I went over to Matt because I knew he was healthy and he was well. And all that other stuff, it was like I was entering another zone when I went over there because of . . .

Des and Gary's twin daughters have been dead for nine years. Des still cries when she talks about that time in her life, and the moments she has missed with her girls. Her twin sons are eleven months old now. Having them has allowed her to reconcile some of the losses she felt with the death of the girls: she is a mother of children, of this child and this child, and she is a mother of twins. Last week, Des found out that she is pregnant again. She is worried that she might have another twin pregnancy, and that the whole "thing" will start over again.

Losing the fantasy of motherhood

During pregnancy, "possibilities are essayed in fantasy", says Rubin (1972, p.106). Fleeting, indistinct images of how it will be, and what it will be like to be a mother, to have, and to hold the child that is growing within. We plan our future with these images in mind. In fantasy, we begin to see ourselves as mother. For most women, the fantasies of pregnancy are woven around images of *this child*. And yet, "to imagine a child-to-be and to begin to see a way to becoming a mother is to lay oneself open for pain" (Marck, 1994, p. 124). When one expects twins, a woman's fantasies are of *these children*, and of becoming a mother to two. She, too, lays herself open for pain. The physical pains of pregnancy, labor, and birth, yes, but other pains as well. "Mothering pains" that leave a woman changed in ways that she may not have imagined (Marck, 1994, p. 124).

For Des, who had no idea that she was carrying twins until after they were born, her images of a single child, and a birth *like this*, did not match the reality of her pregnancy and birth experience. The real did not resemble the imagined. Not only did she birth two children rather than one, but two children who were critically ill rather

than healthy. There was pain in losing her imagined child, her fantasy pregnancy, labor, and birth. There was pain in detaching from her first daughter, and then from her second. There was a sense of being betrayed by her body in having pre term labor. "I felt like my body just wasn't completely working right, wasn't whole. Something's wrong. It's damaged, damaged goods or something." Des's "mothering pains" have dulled somewhat, but not subsided. Even now, nine years after their death, she cries when she speaks of her daughters. Marck (1994) speaks of the pain of mothering a dead child:

> Recently, I returned from a memorial service for the son of a friend. In the eyes of my friend and her husband was pain that is not served up in words. . . . Their son, in death, cannot be with them in the same way as in life, but she mothers him, he fathers him. The pains of mothering and fathering do not stop with the death of one's child. The pains go on, as does the parenting. (p. 125-6).

She lives with pain that does not go away. But, from Des's mothering pain, her losses, suffering, and sense of failing, there emerged a person who would be a mother in a new way (Marck, 1994, p. 124). When her boys were born, she felt "completely ready . . . more in control . . . more assertive about care". Because she was able to have two healthy boys, she felt her body had redeemed itself, she feels "successful" and ready to trust in her body during her third pregnancy.

Janet not only birthed her twins, but in almost dying herself, was birthed back into her world in a new way. She never imagined that after a healthy twin pregnancy, a labor, and a birth, that she would lose her "self" so completely. She is trying to

forge a new 'woman-self', a self who is a mother but who does not have the capacity to have more children. As one who now "takes nothing for granted", Janet is supremely sensitive to each nuance of her twins' behavior, and is totally involved in each new day.

How does one reconcile the mothering pain when attaching and detaching, joy and sadness, and birth and death coincide? Perhaps it will never be reconciled, only acknowledged as just that, the pain of mothers. Angie will not forget that her living daughter is a twin or that another child was lost. There is pain in not knowing the gender of her dead child—with knowing, she would know more about 'who' to mourn. She is trying to forge a relationship with her new baby that recognizes and includes her daughter's twin-ness, rather than avoiding it or excluding it. In recognizing her daughter as a twin, Angie also allows herself to be known as a mother of twins, one twin that has lived and one twin that has died.

The pain of twin pregnancy and premature birth continue for Olivia as she watches her children struggle with their own pain from multiple surgeries and illnesses. Babies are supposed to be healthy, to come home with their mothers, to grow and develop in joy. Mothers are not supposed to be the instrument of their childrens' illnesses. For Olivia, this is not how it was supposed to be. This is not how she wanted it to be.

Each of these women experienced a twin pregnancy and birth. In itself that is a childbearing experience that is out of the ordinary. Within that extra-ordinary experience, each woman experienced mothering pain far beyond the physical pain of

labor and birth, pain that will not leave them, yet leaves them changed in ways they could not imagine.

These are not *just* stories. These women did not just tell their story. Jardine (1997) teaches us that the story itself is telling. When stories such as these are told, "something happens", says Jardine (1997). "It *spoke* . . . . something *happened* in the telling of this story, something 'beyond our wanting and doing.' These tales of collapse and withdrawal [pain and loss] arrived full of address, full of a claim, full, somehow of their own agency and demand" (Jardine, 1997, p. 163). As individuals, we acknowledge their loss. As mothers, we recognize their pain. As health care professionals, we are, in hearing these tales "somehow called to account" (Jardine, 1997, p. 163).

Chapter Nine

Mothering Work

My children cause me the most exquisite suffering of which I have any experience. It is the suffering of ambivalence: the murderous alternation between bitter resentment and raw-edged nerves, and blissful gratification and tenderness. Sometimes I seem to myself, in my feelings towards these tiny guiltless beings, a monster of selfishness and intolerance. Their voices wear away at my nerves, their constant needs, above all their need for simplicity and patience, fill me with despair at my own failures, despair too at my fate, which is to serve a function for which I was not fitted.

Rich (1986), p. 21

Thinking back, I can recall clearly what it was like for me be a mother to two babies in the hospital. Recovering from two months on total bed rest, I found myself with one daughter down the hall from me in 'normal' nursery, and one daughter in the 'step-down' unit of the Neonatal Intensive Care Unit, on a completely different floor in the hospital. I remember being adamant that I would breast feed these babies, no matter what. What I hadn't expected was what was involved in feeding two. I was advised to feed them on 'demand', which means that they ate when they were hungry, but the schedule in the hospital 'demanded' that one daughter be fed about every three hours. The other, smaller daughter, was to be fed every two hours so that she could gain enough weight to go home. The mathematics implicit in this was beyond me at the time. I smile now when I think of it: twelve feedings for one and eight feedings for the other, all in a period of twenty-four hours. Even in contemplating those numbers, how did I eat, shower, rest, recover from my own surgery, come to the realization that I was a mother of *two babies*, and still travel between nurseries, between babies, between floors in the hospital? I managed it for

the eleven days I was kept in the hospital. Then I took one daughter home. I hadn't thought about factoring traveling time back to the hospital into the feeding schedule! Was this what it was like to mother two babies? Was I always going to have to be in two places at once? Was I always going to have to choose where to be? Would I make the right choice? What happens if I am in the wrong place? What then? When my second daughter came home, I remember looking longingly at my friends. They had one baby, took one baby home, mothered one baby, always knew where they were supposed to be, always seemed so refreshed and well organized. There was more 'work' involved in this than I had imagined. What was I going to do? How could I do it?

When we think of the 'work' of mothering a new baby, we think of feeding, diapering, bathing, laundry, sleepless nights, the immediate disintegration of our old life for the disorganization of our new "fragmented existence" (Bergum, 1989, p. 109). In making the decision to have a child, and in becoming pregnant, we know that our lives will change with the introduction of our child into our home. We may not really know what those changes will be about, but we know that there will be changes, and as we move through pregnancy, we come to accept the fact that our lives will change.

When a woman discovers that she is carrying twins, thoughts of two may go through her mind—two car seats, two cribs, two high chairs. And she thinks about what it will be like at home with two babies. If she has had a baby before, she may have an idea of what the 'work' of mothering twins entails. She may speculate, isn't it just double everything? But those who have taken two babies home and are involved

in the 'work' of mothering twins say, "It is more than just doubling everything." "It is a completely different dynamic." The word work is from the Old English, *wyrcean*, meaning the effort one expends that is directed at accomplishing something. Work has been described as an enterprise, a responsibility, an occupation, a profession, an achievement, and a feat. But, what is 'mothering work' like for women who have twins? What is it like to care for two babies, when sometimes they are in separate locations? What is it like to be with one and not with the other? How does one 'work' to become a mother to a sick baby? What is it like to 'have twins'?

Doing what you can

> It was the twilight zone. It really was. The NICU—the first time you go in—is the scariest thing on the planet. The whole delivery, and the whole thing, and you're not prepared for this. I don't think anybody . . . even if you saw it ahead of time, you still wouldn't be prepared for it because they're not your children yet. All this equipment and all the monitors and all the IVs and all the people and all the commotion. And after being here for a month, you tuned it all out. But after that first day I wanted to go back to my room and hide. Because it was just too much. I'll never forget that first day.

For some women, the 'work' of mothering twins begins in a place that they may have seen only on their prenatal hospital tour—the Neonatal Intensive Care Unit. Some mothers have never seen it at all. For mothers, it is a place of unknowns, a scary place where babies go when they "are not doing well", "are having problems", "need to be observed", or "need to have further assessment". It is a place where they need to have more 'intensive' care than other babies and often involves a high degree of

technology—machinery, wires, tubes, drains, and medications. All of these can become a barrier to touch, to closeness, to what we always have thought being a mother is all about.

For some, the work of mothering twins actually begins when they approach the NICU. One woman, "sick to her stomach", and "scared", forced herself to go through the door. Looking around at open cribs, closed isolettes, monitors, IVs, and more and more equipment, she could feel the 'intensity' of 'intensive care'. Without even seeing her babies, she knew she was in a place for sick babies. The place was foreign to her, alien, but it seemed a good place for her babies, her little "aliens", to be. Here, someone who knew what was going on would direct the care for her babies. But the babies, surrounded, covered, wrapped in tubes and such, may seem to be more 'their' baby than 'my' baby. How do 'their babies' become 'my children'?

> I knew exactly what meds they were on, what they're for, what the dosages were, what the reasons for increasing or decreasing them, when they got them. Answer to me when they're late! I knew all of this stuff because I made it my job to know that. I couldn't take care of them at home. I could take care of them where they were and that's what I did. And it made me feel helpless. I mean I couldn't bath them all the time because they couldn't be bathed all the time. I couldn't rock them and cuddle them and sing to them so I did the things I could do. You know we personalized their beds and brought them their own blankets and did things like that. I brought the girls little night clothes to wear because I didn't like them in the hospital clothes. It made them little people, not just Baby A and Baby B.

A mother finds ways she can be involved in mothering work. She does what she can. Her work may not be what she had envisioned, expected, but she learns what a mother with children in the NICU can do and what she cannot do.

Sometimes, a mother cannot 'do' a lot for her babies because they are attached to monitoring devices, so instead of the feeding, the changing diapers, the playing—a mother finds other ways to do the work of mothering. "Okay, I'm in the doctors' faces. I'm in the nurses' faces. I'm in the NICU, you know, 12 hours a day." Sometimes mothering work is being there for her children, involved in every aspect of their care and in every aspect of their lives. She is there to hear the 'good' news or the 'bad' news, to make decisions about this procedure or that one, to watch and watch over her children, to demand to "be part of it all".

> I'm sure the doctors are so sick of my face because I'd push my face in where ever to be involved as much as I could be, because I couldn't be. Does that make sense? . . . I read the doctors' notes every day . . . . I just stuck my face in everywhere . . . . I had to advocate for my son because he couldn't do it for himself.

To "be part of it all" is to take responsibility for your children, to be responsible. The word responsible is from the Latin *respondēre*, meaning to promise in return. The word responsible is related to the word respond, which means to answer, to support, to pledge, and it is also related to the word responsive, which includes an element of being ready to adjust quickly to something. Being responsible for, responding to, and being responsive are ways that women assume the work of mothering. As we respond to the presence of our child(ren) both during pregnancy

and after birth, "we promise to look after the child, to care for the child, to return always . . . . to be, 'one for the Other' " (Bergum, 1989, p. 85). By responding to the need of this child and this child, we pledge ourselves as their advocate, their support, their champion. By being responsive, we learn their individual foibles and cues, and what these could mean: Is he/she hungry? Thirsty? Uncomfortable? Tired? In the NICU, we learn to interpret their oxygen saturations, their monitor readings, their fluid intake, to read their charts, and to adjust our focus quickly. We call someone, we ask questions, we "bother" people with our concerns. We are taking responsibility, we are responding, we are being responsive. We are doing mothering work.

For women with sick babies, worry, fear, and pain become part of their everyday existence. They speak of "getting through it", through that period in their lives where their pregnancy has ended, and they are faced with more events that they had not expected. How do they "get through it"?

> Knowing the fact that I'm not super mom got me through it. I could only do as much as I did. I could only be in so many places. I could only do so much for both our kids and I was doing the maximum I could do. I couldn't do any more.

They face their own limitations. "What can I do and what can I not do in this NICU?" they ask. They "put oneself in question, which can involve change, an inner change, in a woman's understanding of herself" as mother (Bergum, 1989, p. 102). A woman's expectation of how she would mother twins becomes the reality of the two babies before her. She confronts her own expectations of herself as mother—a mother holds her children, touches her children, spends time with her children—and

reconciles her expectation with her reality—she may only be able to touch her child's hand or foot. "I wanted to touch them, and obviously I couldn't touch them. [The nurse said] no go ahead. They had saran wrap all over them. I got to touch their feet."

The work of mothering in the NICU is not "natural mothering". Mothers are 'monitored', just as their twins are monitored. They feel the "overlooking eyes". "The babies are not yours. You get to visit them but they are not yours." Mothering in the NICU is a "careful" mothering, a "guarded" mothering. Mothers feel themselves being watched. Am I doing something wrong with my babies?, they ask themselves. I might have done something wrong to cause this situation, to have my babies here. Now I feel like I am still doing something wrong. The guilt, the being responsible for wrongdoing, goes on. Bergum (1989) says that the guilt of mothers comes with caring for a vulnerable, helpless, dependent, and sometimes crying "Other", and unable to help or to comfort, to make a difference, one feels out of control (p. 102). For women with two sick babies, vulnerability, helplessness, dependency, and lack of control characterize their own existence as well as that of their 'Others'.

Women who have twins in the NICU do mothering work, but it is when they go home with their babies, when they are solely responsible for their care, that they begin to truly feel that they are a mother.

> It was a reality that came—I'm a mom. It wasn't really a reality until I brought Chad home that I was really a mom, not just this thing that was going to take care of these babies. I felt it. I felt like a mom because he was actually in my arms, in my care, and I didn't have people telling me what to do, when. I could do it when I wanted, or when we wanted.

> My time got spent back and forth you know. I would hold one for a little while, put him down, let him calm down and relax, and then I'd go and be with the other . . . . I was a yo-yo. I was just back and forth, back and forth.

To be a mother of twins is to be "split" between two babies, to be torn apart. Whether both are hospitalized, or one is at home and one is in the hospital, or even if both babies are in your arms, a woman with twins is torn between the two, to have this child on one's mind, *and* this child on one's mind. When one is with one child, the other's presence is felt.

Bergum (1989; 1997) says that to have a child on one's mind is to turn one's focus to that child, to have one's attention divided between self and Other. There is an implicit 'equalness' to division—one divides equally and there may be a 'remainder'. When one has twins on one's mind, one's focus is not just divided equally with a bit left over, but it is splintered, split, between the two. One's attention to the Others, to *this* one and *this* one leaves a mother torn. When they are crying, who do I go to? When they are both sick, who do I hold? Someone once told me that a mother of twins goes to 'whoever needs her the most'. But, how does one decide?

I vividly remember coming home one day when my twins were about twelve months old. Meeting me at the door, they were falling over each other, holding out their arms, pick me up, pick me up. Looking at their little eager faces, all smiles, I knew that picking one up would disappoint the other, would make one feel the favored one and one the rejected one. I remember railing again at the things I had to remember, to be aware of, to think about, that my friends without twins did not. Will

a woman ever be sure that she made the right decision in 'picking up' one before the other, in focusing on one instead of the other? Will she always live with the uncertainty of perhaps doing something else wrong?

The first night

> I could barely walk, I was in pain from when they breastfed, you know, with the uterus contracting like that. You're still bleeding, like it was the first night, and we don't have people waiting on us hand and foot any more . . . what is going on here? They cried all night. In the morning when we got up there were dirty rolled up diapers all over the floor. It's sort of like you know as fast as you feed them they would pee and they would poop and I was just throwing here and there and everywhere and it was just awful. Just truly awful. It was sort of . . . oh my gosh you know this is just terrible. I can't . . . I don't think I'm going to make it, you know that is how I felt. It was like what am I going to do? I kept thinking, my mother is here but eventually she is going to go back.

While a woman is pregnant, there are visions of taking her baby home. The popular literature about twin pregnancy and twin mothering prepares a woman for twins by listing items she might buy to make her work easier—bottles, breast pumps, dozens and dozens of diapers, clothes, and so on (Clegg & Woolett, 1983; Rothbart, 1994). They tell her not to turn down any offers of 'help' and be sure to get lots of rest. The nursing literature aimed at educating nurses who care for women who take twins home speaks only of feeding, stress, lack of time, scheduling, positioning (Theroux, 1989) and coping skills, family support, and teamwork (Bowers, 1998). So,

when a woman takes twins home she may 'know' of these things, but does she really 'know' what to expect when she goes home? Is she really prepared?

> The first night was really hard and I really wished that someone would've told me that it would've been as hard as it was. I had no idea . . . . Lily wasn't eating properly and I didn't know that. She was breast feeding and she wasn't getting any milk. She wasn't swallowing properly. She obviously was hungry which I didn't know and she screamed all night and I was just a mess in the morning. I had not planned to have any help because you know I can do it. Then I phoned my mom at six in the morning crying. "You have to come over," I said . . . . It's just, two was so much different. I thought, oh I can do it. There's no problem. Two can't be that much harder than one. But when you don't have two sets of arms to hold them, even to comfort them for a while, it's hard.

For some women, the first night at home is the first time that they are alone with their twins. Often, it is the first time that they, alone, care for two babies without the "security" of having a health care professional nearby. Perhaps their husband is at work, or sleeping in preparation to go to work. It is during the first night that women's doubts of 'I can do it with one—I can't do it with two' may be realized. The excitement of finally being at home with her children may become lost in the realities of their dependent demands—feeding, changing, crying, needing. By the time morning comes, she is tired, frustrated, and unsure of her ability to continue her work. One woman recalled telling her husband, "I'm going to go into that bathroom and I'm

not going to come out for twenty years!" The work of mothering twins is a seemingly insurmountable task. How do mothers of twins 'work' to get the work done?

Finding the way

> She always wanted me to feed them both at the same time and I guess I was trying to explain to her that if it can't do it myself it's not worth me learning because you know I'm not going to have someone always there beside me helping me put them on and stuff like that.

It seems like everyone wants to give advice to mothers who take their twin babies home—nurses, physicians, husbands, friends, their own mothers and mothers-in-law. Do it *this* way, feed them like *this*, get them to sleep like *this*, put them *here*. Everyone wants to help. Yet mothers say that much of the advice they are given comes from others' experience with a single baby rather than from someone who has had two babies. What seems to be missing in their advice is an understanding that a mother is constrained by her twins in ways that are hard to imagine, and hard to predict. Yes, she can feed two at the same time. And yes, it will save time. But, after she has positioned one baby in her arms, how does she pick the other one up, position that baby without disturbing the other feeding child, and proceed with feeding them both safely? Feeding them both at the same time seems to necessitate having another person close by to help a mother position her babies for breast feeding, and also for bottle feeding if she desires to hold them both for their feeding. What happens when she is breast feeding two babies and one of them regurgitates? When her arms are full of babies, how does she stop the feeding to burp one or both children?

With twins, actions that we take for granted, or feel are simple everyday actions, are difficult. Finding a way of doing things that works for her means that she has to think about what she is going to do, to think ahead, to plan ahead.

> You really have to think about things. Can I physically do that? You know I tried to do everything that I did with the first. Some things you just can't do. You can't go grocery shopping. The only place I can go is Costco because I can fit both car seats in one cart. Those huge car seats but that's the only place I can grocery shop by myself and I don't like that. I don't like having to rely on people that much so we shop a lot at Costco. It's just, like IGA, I can go around with my stroller and get a little bit but then you can't fit through their lanes with strollers . . . . Everything that involves going out—it's just a little bit harder.

Grocery shopping, going out for dinner, going to a movie, getting a babysitter, even just getting ready to go out anywhere, requires careful planning and organizing. A mother needs to feed, change, and dress one baby, and feed, change, and dress the other baby, as well as get herself ready before going out the door. One mother, who wanted to go on a walk-a-thon told her husband, "We have to get up two or three hours before so I can get everybody ready and feed them and everything." She says, "It didn't click with him." He was still thinking, "Oh we can get up, and in an hour we're all there."

"I have to think before we can do anything. I think, how can I make it work so we can do that?" Planning and organizing for the shortest excursion is exhausting mental work. Sometimes, mothers feel that it is easier to go out without children, or

with only one of their children, or not to go out at all. Going somewhere without children brings with it another set of challenges. Who can you leave your twins with? Who can handle the constant demands of two babies? Some mothers are even reluctant to leave their babies with their husbands, because they "don't have the system down pat". But if she takes both of them out, and they both become fussy, cry, or need something in the middle of a restaurant, a mall, or a library, what then?

"It was just trying to make myself available to them all." Sometimes it is just impossible to do everything a mother wants to do for her twins, especially if she has other children to care for as well. So women do not deny other womens' offers to help. They share the mothering of their twins with other women. Aunts, neighbors, sisters, cousins—other mothers, women, who through their own experiences with children, can recognize what needs to be done and can jump in and help feed, change, fold laundry, just hold and comfort a baby, or play with an older child. "Thank God for Grandma! Cause she was down here every day, still comes down here every day. But that's okay, they need loving." Some women seek the warmth, closeness, and comfort of another woman's arms for one baby, so they can give themselves to their other baby. "She [baby] sure likes me to take her places when other people want to hold them, because then you can get other people to hold Beth and I can spend the time with her." Then a mother knows that both babies will be held, hugged, and comforted.

Recreating moments

Twins mean two baths, two cribs, two car seats, two children demanding to be fed, changed, and comforted. Physically, what a mother does for one, she does for the

other. She bathes one this way, and probably bathes the other in a similar fashion. She changes one and then the other, probably again in a similar fashion. This is the routine of physical care. She is responding to their physical needs, and her actions are responsive to their physical needs. Her responses are the same: change one, change the other, feed one, feed the other. There is a sameness in her actions as she responds, a re-creation of her actions. Is this re-creation only with physical care, with the monotonous litany of doing for one, doing for the other, or are there other re-creations in a mother's work with twins?

> Say Michael was crying. I had to hold him. If I calmed him down and then I could play with him, and whatever happened you just interact, right? But if I'm interacting with Michael and then I see Matthew just sitting there, well I've got to do the same thing. I have to end this what I'm doing with Michael, put him down—you're happy now—and pick up Matthew and then we'll engage and interact. I feel like I have to do some things twice. I mean it's not as spontaneous . . . . I think if you had one at a time you would have those special moments without having to make it happen with the other one . . . . Sometimes you don't even think about it, but at other times you know you want to keep it even. I don't even know if 'even' is the word I should use. It's just that you want to give them both the same experience. You want to give them lots of attention I guess. You want them both to have lots of attention like they would if they were an only baby. You know you can't completely do that but you still try.

Mothers try to re-create moments, to capture a moment with one twin, and to re-create that moment with the other. In the capturing of a moment with one, there is a seizing, a containing, an acquiring, a taking. In re-creating that moment with the other, there is a coming into being, a making, a sense of being contrived. In being contrived, the moment with the other twin loses its spontaneity, its qualities of being natural and unconstrained, of just happening. In re-creating moments with one, mothers desire to give each twin the same experiences, the same attentiveness, the same parts of themselves. They want to be fair, to be equal. "If you kiss one, you have to kiss the other." There is mental work in recognizing that one twin is being left out of the dynamic of being two together, and physical work in actually re-creating the hug, the kiss, the cuddle, the play. But, in re-creating the moments for one twin, she is re-creating the moments for herself. She is mothering twins.

Chapter Ten

Ongoing Conversation

> *Dealing with this phenomenon well, understanding it deeply and generously and speaking its truth, might also be a problem of character, of wisdom, of patience, of becoming someone who can hear and tell the truth of the tales that their own lives tell, unafraid, willing to not blunt the intractability of living one's life with troubles . . .*
>
> *Jardine, 1997, p. 165*

This work began with the question, what is it like to be 'having twins'? In responding to the question in a hermeneutic-phenomenological way, I have considered what it is like for a woman to desire a child, to achieve a pregnancy, and then to be given a twin pregnancy. In attempting to encourage its various aspects and nuances to become more explicit, I have tried to grasp and expose some of the meanings carried with the word 'twin' in our society. And I have attempted to present twin pregnancy, twin birth and loss, the initial mothering of two infants, and the meaning inherent in these experiences as they are lived by women in our society.

Jardine (1992) teaches us that there are widespread possibilities of meaning embedded in any incident—the conversation is never finished, the interpretation is never finished. So, it is now time for me to stop "the spinning out of implications of meaning" (Jardine, 1992, p. 59) and to ask three questions: How has this interpretive account fostered our understanding of the topic? If we, as nurses are attentive to what is needed for ethical action, how should we act when faced with a woman who is 'having twins'? How has my understanding of myself and the life I am living been transformed by this work? In this final chapter, I will explore my response to these questions.

How has this interpretive account fostered our understanding of the topic?

This account has re-written the mothering story to include mothers who carry and birth two children at the same time. The challenges of pregnancy, birth, and the initial mothering period are multiplied. The decision to have twins is not a decision that women make. They may enter into the idea of having a child, but the idea that they are expecting twins, will birth two babies, and mother two babies, is one that women cannot initially comprehend.

The physicality of twin pregnancy goes beyond that of a single pregnancy for some women—they are aware of their body and its generativity in a different way. One body must accommodate two unborn children. Not only are size, movement, and comfort affected, but the 'risk' label is attached, a label which can provoke worry, fear, distress, and even denial about what is occurring during pregnancy. A woman can *acknowledge* that her pregnancy may be at greater risk than other pregnancies, but if she does not *feel* at risk or high risk, she may not comply with recommendations made by her health professionals regarding such things as rest or the curtailing of employment.

It is through the visual link during an ultrasound examination that a woman begins to realize her twin pregnancy. Although the images that she sees may not look like babies, the visual link allows her to begin acknowledging herself as woman-with-two. She is told that the visual images she sees are her two unborn children, and as her pregnancy progresses, she gets to know her children and the details of their existence in utero via a visual picture on the ultrasound screen.

When a woman has been diagnosed with twins early in pregnancy, her experience of quickening is changed. She feels her babies begin to move. At the time of quickening, discerning which one is moving cannot be done. She is claimed by two, by the Others. At the moment of quickening, she is morally bound to two.

To a woman carrying twins, time takes on different meaning. She anticipates the birth as an event that could take place anytime instead of on or by a definite due date in the future. Rather than focusing on the readiness of her environment, a woman must become mentally ready for the birth. She holds the babies within her body as long as she can. Sometimes she endures intense scrutiny of her pregnant self by health care professionals, before her babies are released into the world.

Before the birth women who are pregnant with twins are cared for by their community. As part of the community of women and the community of mothers, they are given special or privileged treatment, but care can also take forms that are unexpected, such as advice, restrictions, or stories about other births.

At the time of twin birth, medical surveillance is maximized to prevent any negative birth event. Although women who are birthing twins may feel in control of their labor and birth and wish to let nature take its course, they are put into situations that deny them that control. They undergo surgical deliveries, augmented deliveries, inductions, and they are anesthetized. They are "confined, managed, and delivered" (Bastian, 1992). At twin birth, there is an anticipation of failure. Women are managed to prevent that failure from occurring.

Loss is a part of the twin mother story. Women who carry and birth twins are in greater danger of experiencing a loss. They fear a pregnancy loss. Their fear keeps

them vigilant, looking ahead to the next milestone—the next gestational week, the next doctor's visit, the next ultrasound--alert to something, anything, going wrong. Their losses may be chronicled in different ways. Mothers may lose their fantasy of the perfect pregnancy and the perfect birth through illness, prematurity, and death. At the birth, mothers may be given one child and have one child taken away at the same time. There may be no separation between these experiences. How can a woman continue to live her life as mother with these conflicting events--one joyous, one grievous? Pain and loss are part of mothering work. They go on and care for their existing child, trying to make sense out of their experience.

In twin pregnancy and birth, the mother-child relationship is itself always multiplied. Relations become confusing and difficult to articulate: mother-child, mother-child, child-child, mother-children. These relations become more confusing when they are linked with other aspects of twin mothering such as the NICU, or sharing their mothering with spouse, partner, parent, friend or volunteer.

If we, as nurses, are attentive to what is needed for ethical action, how should we act when faced with a woman who is 'having twins'?

We must create moral space. Anderson (1998) says that when we listen to women about what it is like to live, we begin pointing to the moral life, instead of talking about it. In our listening, we create moral space—space for questions, space for action. It is within moral space that our questions of "Why?" and "How should we act?" dwell. It is in how we answer these questions that we begin to realize how we can be attentive to what is needed for women who are having twins.

We must re-write this woman into this pregnancy. In caring for mothers of twins, we need to focus on *this* woman-as-mother rather than on her pregnancy. I am not suggesting that we do not need to know about pregnancy, but to take ethical action in pregnancy situations, we need to know about *this* woman and *this* pregnancy. We must link our abstract knowledge about pregnancy to our inherent, constructed knowledge of this person as "a living person where body and self are one" (Bergum, 1994, p. 73). In focusing on the woman from the perspective of "life as lived" rather than "life as analysed", we can begin to discover knowledge that is "irreplaceable and unique to *this* relationship, *this* patient, and *this* [nurse]"—knowledge that provides the basis for ethical action (Bergum, 1994, p. 74).

We must create, in our own experience as nurses, a moral party of more-than-two. Women who carry and birth twins are claimed by two, by the *Others*. Bauman (1993) teaches us that to be for the other "means listening to the Other's command" (p. 90), a command that is an attention, a response, an innate moral impulse to serve. "If being-for means acting for the Other's sake, it is the Other's weal and woe that frame my responsibility, give content to 'being responsible' " (Bauman, 1993, p. 90). With twins, a mother is claimed by two, acts for two, is responsible for two. And sometimes, the claims, the acts, and the responsibilities set up conflict within her as mother. Who do I go to? Who do I hold? This one or this one? What do I do next? As nurses, we need to re-frame the responsibility of the mothering relation to include women who simultaneously carry and birth two children. We need to acknowledge the complexity of the 'claims' of twins, and search for a way to help *this* mother respond to the claims of *this* child **and** *this* child.

We must re-write the mothering story to include situations of loss, grief, and pain. Mothers tell us that they are afraid that "something might go wrong". They fear loss, and the pain and grief that accompanies it, yet as nurses, the fears of 'something might' are often not acknowledged with mothers. When the 'something' does happen, mothers feel guilty, abnormal, cheated. With women carrying twins, we need to link our abstract knowledge about what might happen in twin pregnancy with our constructed knowledge of what is happening with this woman's pregnancy, and be sensitive to their fears of loss. If a loss does occur, we need to support them, to be there for them in their loss, and to affirm them as mothers and as mothers of twins.

We must re-interpret twin pregnancy and birth as safe. As nurses, we enter into a relationship with a woman who is carrying twins with our abstract knowledge about twin pregnancy in the forefront of our minds. Numbers and statistics about prematurity and other complications impel us to view this pregnancy as a 'risky' event. We assess and teach focused on what might go wrong rather than on what—right now--is going right. We sometimes forget that this pregnancy, like any other pregnancy, has the potential for complications, but that it also may follow an uneventful course. In our desire to protect this pregnancy from potential harms, we anticipate failure. We sometimes forget that a woman may have an uneventful twin pregnancy and birth. This needs to be recognized and encouraged by all types of health professionals. Questions need to be asked of every twin pregnancy and birth: How many individuals should be present at this birth? How many assessments and interventions are necessary to ensure that 'nothing will go wrong'? What is appropriate for *this* woman in *this* situation?

How has my understanding of myself and the life I am living been transformed by this work?

> To answer this question, I must turn to Packer's (1989) words:
>
> When practical understanding breaks down, when it meets with interference, with a block or barrier, our engagement in the world changes to one of circumspection (from ready-to-hand to the unready-to-hand mode). This brings about transformations in our awareness of ourselves, of our activity, and of the people and setting we are dealing with. Each of these becomes thematized: where previously they formed an opaque totality that was the background or context to our action, now they become laid out with a transparent discernible organization. (p. 107)

In retrospect, I realize that my practical, everyday understanding of twin mothering from the perspective of mother did not mesh with what I saw in everyday nursing and medical practice. The "opaque totality" of the topic seemed to me to be less opaque, less impenetrable—less a closed issue than it appeared to be (Packer, 1989, p. 107). In posing my questions and investigating them in an interpretive manner, and in presenting this interpretive account, I hope to lift some of the opaqueness of the topic for others who live and work with women who are having twins. Perhaps then, in an ongoing conversation, we will pose and respond to more questions, keep the conversation open, and disturb the topic's opacity even more.

I have learned to question—to live with being open, with being unsure, to step away from what feels comfortable and enjoy the discomfort, even look forward to it. I have learned to ask, but not to just ask and be satisfied with whatever answer first

comes to mind. I have learned to be open to the possibilities before me, letting the topic be intractable, contradictory, and ambiguous. I have recognized its diversity. I have learned to be secure in not knowing its 'answer'. In presenting this interpretive account to you, I know that the interpretation is not 'finished'—it is just a beginning and the conversation must go on.

Perhaps transformation also lies in deciding how one might continue "living the questions" about twin pregnancy and mothering (Bergum, 1989, p. 154). My questioning sends me to live my everyday nursing practice with these women, their babies, and their families. In doing so, I can keep the conversation open with women and their families about what it is like to mother and parent twins, with caregivers about how we should act when we care for these families, and with other researchers about the questions that still need to be explored. Perhaps I can raise the level of conversation in the community about families who have twins, and the issues and challenges that they face in their everyday lives. And I can be right there, enmeshed in the topic with all of them.

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Appendix A

Recruitment from Multiple Birth Organization

Title of Research Study: Twin Pregnancy: An Interpretive Inquiry

Researcher: Jeanne Van der Zalm, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone: 492-5924

Supervisor: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

ARE YOU PREGNANT WITH TWINS?
HAVE YOU HAD TWINS IN THE PAST?

ARE YOU INTERESTED IN VOLUNTEERING TO BE IN A RESEARCH STUDY ABOUT TWIN PREGNANCY?

I am a nurse and a mother of two sets of twins. I am doing a research study to learn more about women and twin pregnancy. This study is part of my doctoral program.

The purpose of this study is to learn what it is like for a woman to be pregnant with twins.

Women who agree to be in this study will be asked to talk about their experiences of twin pregnancy. It will be like an informal conversation.

If you are pregnant now, we will talk at different times during your pregnancy. After the twins are born, we will talk again when they are about 6 weeks old.

If you are not pregnant now, we can talk at a time that is good for you.

Each conversation will take about one to one and a half hours. The conversations will take place in your home (or in another place that is good for you), and at a time that is good for you.

If you would like to hear more about this study, please call me at XXX-XXXX (this is NOT long distance from XXXX). We can talk further about the study. After I have explained the study to you, you can decide if you would like to be a part of this study.

Appendix B

Biographical Data of Women Participants

To help me understand my findings, I would like to have some additional information about you. If there are any questions that you do not want to answer, just leave them blank. All information is confidential. This information will be included in the final report, but it will be done so that you cannot be identified.

How old are you?_____

What is your marital status?_____

What is the highest level of education you have obtained?
_____below high school
_____high school
_____college/technical school
_____university
how many years?_____
highest degree?_____

What is the current yearly level of income in your family?
_____less than $24,999
_____$25,000 to $29,999
_____$30,000 to $39,999
_____$40,000 to $49,999
_____greater than $50,000

How many times have you been pregnant?_____

How many times have you been pregnant with twins?_____

Are you currently pregnant with twins?_____
If not, how old are your twins now?_____

If you are currently pregnant with twins:
When are these babies due?_____

How many weeks pregnant are you now?_____

Was this pregnancy planned_____or unplanned_____?

Do you know the sex of the babies? Yes_____ No_____

Do you know whether the babies are identical or fraternal?_____

Have you had any complications with this pregnancy? _____ If yes, what kind?

Appendix C

Information Letter for Women Participants: Group Conversation

Title of Research Study: Twin Pregnancy: An Interpretive Inquiry

Investigator: Jeanne Van der Zalm, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone: 492-5924

Supervisor: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

Purpose of this Study: The purpose of this study is to learn about womens' experiences of twin pregnancy.

Procedure: Women who are nearing the end of a twin pregnancy or who have been pregnant with twins at some time will be asked if they want to be a part of a group discussion.

In this study, you will be asked to come to a group and talk about your experiences of twin pregnancy. At the end of the meeting you will be asked to write down one experience that happened to you in your twin pregnancy. There will be about 8 women there. The meeting will last about 1 to 3 hours. The meeting will take place in a location that is convenient for the women who are participating. If you have parking expenses or child care expenses because of the meeting, I will pay for them. The meeting will be audio-recorded and a written copy of the audio tape will be made. A research assistant will be at the meeting to help me.

Participation: There are no known health risks resulting from being in this study. Some women find it beneficial to be able to talk about their experiences. Results from this study may help improve the care that nurses give to women and families who are expecting twins.

Voluntary Participation: I want you to know that you do not have to be in this study. If you decide to come to the focus group and then change your mind, you can drop out at any time by just letting me know.

Confidentiality: Your name will not appear in this study. Your name will not appear in any written record of the group discussion. I will ask you to write your name and address in pencil on your written experience so that I can send you a copy of what you have written. After I have sent you a copy of your writing, I will erase your name and address from your writing. A copy of your consent form will be kept in a locked

place. Only the researcher will have access to this information. The conversation from the group discussion may be used for another study in the future, if the researcher gets permission from an ethical review committee.

The information and findings of this study may be published or presented at conferences, but your name or any writing that might identify you will not be used. If you have any questions or concerns about this study at any time, you can contact me or my supervisor at the given telephone numbers.

Anonymity: Other women that you might know who have had twins or are pregnant with twins, or women that might know you, may attend the focus group. If this happens, they would be able to hear anything that you wished to share with the group.

Appendix D

Guide for Conduct of Group Conversation

1. Welcome.

2. Introductions to researcher and research assistant.

3. Facility details.

4. Purpose of research.

5. Purpose of the focus group.

6. Role of the researcher and research assistant.

7. Review of data collection, confidentiality, anonymity.

8. Consent.

9. Rules for group behavior: Use of first name only, limit speaking to one person at a time.

10. Group Interview Guide (Kingry,Tiedje, & Friedman, 1990):

    Examples of general introductory questions: I'd like to start by going around the group and have each of you mention *one* change in your life that occurred since finding out you were pregnant? *One* change in your life that occurred since finding out you were pregnant with twins?

    Examples of questions that progress from general to specific: Women have said that twin pregnancy is a very different experience than a singleton pregnancy---what do you think they mean when they say it is different? What differences could you identify in your pregnancies?

11. Narrative writing exercise.

12. Closure.

Appendix E

Group Narrative Writing Exercise

Excerpt From:

MELONS/AT THE SPEED OF LIGHT
by Bronwen Wallace

I keep having this dream
where the women I love swell up like melons, night after night.
It's not surprising, really.
They've reached that age
where a woman must decide once and for all,
and this summer, most of them are pregnant.
Already their eyes have changed.
Like those pools you discover once-in-a-while,
so deep within themselves
you can't imagine anything else swimming in them.
The eyes of pregnant women. The women I love
fallen into themselves, somehow, far beyond calling,
as if whatever swims in their bellies
were pulling them deeper and deeper.

Process:
I am going to read a poem about pregnancy to you. I want you to listen, then to pick up your pencils and write about whatever came into your mind while I was reading the poem to you. I will give you five minutes to write.

Begin your writing with the words: *I remember . . .*

Appendix F

Letter of Ethical Approval

Appendix G

Information Letter for Women Participants: Individual Conversations

Title of Project: Twin Pregnancy: An Interpretive Inquiry

Investigator: Jeanne Van der Zalm, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone: 492-5924

Supervisor: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

Purpose of this Study: The purpose of this study is to learn about womens' experiences of twin pregnancy. This project is part of my doctoral program in nursing.

Background: More and more women are having twin pregnancies. But not very much is known about what that pregnancy is like. I would like to talk to women who are pregnant with twins now, or who have been pregnant with twins in the past.

Procedure: Women who have the experience of twin pregnancy will be asked if they want to be a part of this study. In this study, you will be asked to talk about your experience of twin pregnancy. These conversations will last about 1-1 ½ hours. If you are pregnant now, talks will take place about every 6 weeks during your pregnancy, and once when the twins are about 6 weeks old. The total time involved in the study will depend on how far along you are in your pregnancy. The total time involved should not be more than 10 hours, if we talked for the first time at the beginning of your pregnancy. The talks will take place in your home at a time that is good for you. If another place other than your home is better for a meeting, then a different place will be arranged for the meeting. The talks will be audio-recorded. A written copy of the audio tape will be made. If you are not pregnant now, we will talk about your experience of twin pregnancy for about 1-1 ½ hours. If we have not finished our talk then, we may talk again at another time. The total time involved in the study will be not more than 3 hours. The talks will take place in your home at a time that is convenient to you. If another place other than your home is better for a meeting, then a different place will be arranged for the meeting. The talks will be audio-recorded. A written copy of the audio tape will be made.

If you would like to, you can also talk with other women who have had a twin pregnancy experience in a group conversation. There is a separate information letter for this group.

Benefits and Risks: There are no known health risks resulting from being in this

study. Some women find it beneficial to be able to talk about their experiences. Results from this study may help improve the care that nurses give to women and families who are expecting twins.

Voluntary Participation: I want you to know that you do not have to be in this study. If you decide to be in the study, you can drop out at any time by just letting me know. If you heard about the study at your doctor's office and you decide not to be in the study or you decide to drop out of the study, your care will not change.

Confidentiality: Your name will not appear in this study. A false name will be assigned to your written record instead of your real name. Your name will not appear in the transcript of our conversation. Your name and false name will be kept in a locked place. Our typed conversation will be kept in a separate locked place. Only the investigator will have access to these places. These may be used for another study in the future, if the researcher gets permission from an ethical review committee.

The information and findings of this study may be published or presented at conferences, but your name or any material that might identify you will not be used. If you have any questions or concerns about this study at any time, you can contact me or my supervisor at the given telephone numbers.

Appendix H

Consent to Participate: Individual Conversations

Title of Project: Twin Pregnancy: An Interpretive Inquiry

Investigator: Jeanne Van der Zalm, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone: 492-5924

Supervisor: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study?
Yes No

Have you read and received a copy of the attached Information Letter?
Yes No

Do you understand the benefits and risks involved in taking part in this
Yes No
research study?

Have you had an opportunity to ask questions and discuss this study?
Yes No

Do you understand that you are free to refuse to participate or withdraw from
Yes No
the study at any time? You do not have to give a reason and it will not affect your care.

Has the issue of confidentiality been explained to you? Do you understand
Yes No
who will have access to your records?

Do you understand that if any information about abuse of someone under 18 years of age is disclosed by you during the study, the person conducting this study is under legal obligation to report it to the proper authority?
Yes No

This study was explained to me by:

I agree to take part in this study.

Signature of Research Participant:

Date:

Printed Name:

Witness:

Printed Name:

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

IF YOU WISH TO RECEIVE A SUMMARY OF THE STUDY WHEN IT IS FINISHED, PLEASE COMPLETE THE FOLLOWING:

NAME

ADDRESS

Appendix I

Consent to Participate: Group Conversation

Title of Project: Twin Pregnancy: An Interpretive Inquiry

Investigator: Jeanne Van der Zalm, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone: 492-5924

Supervisor: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study?
Yes No

Have you read and received a copy of the attached Information Letter?
Yes No

Do you understand the benefits and risks involved in taking part in this
Yes No
research study?

Have you had an opportunity to ask questions and discuss this study?
Yes No

Do you understand that you are free to refuse to participate or withdraw from
Yes No
the study at any time? You do not have to give a reason.

Has the issue of confidentiality and anonymity been explained to you? Do you understand who will have access to your records?
Yes No

Do you understand that if any information about abuse of someone under 18 years of age is disclosed by you during the study, the person conducting this study is under legal obligation to report it to the proper authority?
Yes No

This study was explained to me by:

I agree to take part in this study.

Signature of Research Participant:

Printed Name:

Date:

Witness:

Printed Name:

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

IF YOU WISH TO RECEIVE A SUMMARY OF THE STUDY WHEN IT IS FINISHED, PLEASE COMPLETE THE FOLLOWING:

NAME

ADDRESS

Appendix J

Research Literature: Twin Pregnancy and Mothering[19],[20]

*ordered chronologically

Qualitative Methods: Pre and Post Birth Periods				
Citation	**Approach**	**Sample**	**Purpose**	**Findings**
Frazer, 1977	case study	n=1 woman	investigate the work of a multigravida in becoming the mother of twins	work existed in 2 aspects: identification of the twins and management of twin care
Goshen-Gottstein, 1980	nonparticipant observation in the home (conducted in Israel)	n=4 families of twins n=6 families of triplets n=4 families of quadruplets	to discover some of the basic issues that face a mother of multiple infants	reports many dilemmas of raising more than one infant at a time: ambivalence, identification, stress
Dickerson, 1981	case study	n=1 mother of twins	none stated reviews case of mother separated from twins at birth	recommends nursing actions designed to facilitate attachment based on case
Leonard, 1981	interview (no specific research approach specified)	n=3 mothers of infant twins	to examine the area of role in relation to mothers of infant twins	3 areas of stress in relation to role: parental, marital, personal; recommends nursing actions for postpartum depression and parents of twins

[19]This appendix is intended to acquaint the reader with the quantity and scope of the research literature available related to the mothering of twins. The review of the literature incorporates both computer and manual searches. MEDLINE, PSYCHLIT, ERIC, and CINAHL computer searches were completed for the time period from 1982 to May, 1999. A manual search for the Cumulative Index to Nursing and Allied Health Literature was completed from 1975 to 1982. Terms searched were: pregnancy, twins, multiple pregnancy, multiple gestation, mothering, multiples, parent-child relations, mother-child relations, triplets, in vitro fertilization. These terms were searched in relation to the antepartum, intrapartum, and postpartum periods of pregnancy.

[20]Showers & McCleery (1984) reviewed the research literature related to twins from 1955-1984. This review reveals only 3 articles generated from a nursing perspective. Of these three articles, only Abbink, Dorsel, Flores, Meyners, & Walker (1982) is research based. The remaining two articles, Linney (1980) and Terry (1975), are descriptive, theoretical discussions relating to aspects of twins such as emotion and individuation.

Qualitative Methods: Pre and Post Birth Periods				
Broadbent, 1986	interview, once at 5 weeks prebirth and once at 5 weeks postbirth (no specific research approach identified)	n=28, mothers of twins or triplets (specific numbers unspecified), matched with a singleton group for age, number of children, and SES	to study the effect of a multiple birth on the family	3 major concerns of women: apprehension about the birth, worry about the wellbeing of one or both babies, anxiety about coping with two babies
Anderson & Anderson, 1987; 1990	grounded theory	n=10 mothers of twins	to provide a detailed description and theoretical analysis of how mothers develop a relationship with twins during their first year of life	mothers need to differentiate between the twins' personalities and physical characteristics in order to relate to them as distinct individuals
Van der Zalm, 1994; 1995	grounded theory	n=10 women pregnant with twins	to describe and propose a beginning theory of the relationship between a mother and her unborn twins	women develop a relationship with their twins via the process of accommodating the twin pregnancy into their lives; suggested 11 propositional statements derived from study findings

Quantitative Methods: Pre and Post birth Periods				
Citation	**Measure**	**Sample**	**Purpose**	**Findings**
Abbink, Dorsel, Meyners, & Walker, 1982	survey (no information given about the survey or its administration)	n=18 mothers of twins	examine how timing, proximity, and monotrophy influenced bonding experiences with both babies	no differences in bonding between mothers who were separated from their babies and mothers who weren't; little indication of preferential bonding; overall mothers described positive attitudes and feelings toward both babies immediately after birth
Robarge, Reynolds, Groothuis, 1982	information sheet to extract data from birth records; 25 item questionnaire adapted from an (at that time) unpublished interviewing tool developed by Altemeier, Vietze, Sandler, Sherrod, & O'Connor administered once (no information re this tool could be found in subsequent literature) compares groups	n=38 families with twins n=97 families with singletons; matched for birthdate, maternal age, race, SES	hypothesis: that a higher potential for abuse might exist following the birth of twins	birth of twins appeared to increase significantly the risk of subsequent child abuse (possibly of another child in the family); acknowledges that abuse is a result of many factors; questionnaire not useful in identifying families at risk of abusing a child (due to timing of questionnaire, unwillingness to describe life circumstances, untruthful answers to questions); all mothers indicated that the hcp did not perceive their increased need for emotional support and health education following the twin birth

Quantitative Methods: Pre and Post birth Periods				
Citation	**Measure**	**Sample**	**Purpose**	**Findings**
Malmstrom & Biale, 1988	2 retrospective uncontrolled questionnaire surveys (no specific information given about the questionnaire) administered once post birth	n=336 mothers who had recently delivered more than one infant	to determine whether reports of the factors which led mothers to suspect twin pregnancy independently of their physicians' diagnoses may be useful in the improvement of the early diagnosis of twin pregnancy	womens' reports of suspicion of twin pregnancy may be accurate as early as the first month and that primiparous and multiparous women are equally able to recognize twins as 71.1% of women reported self diagnosis; recommend multiple screening for twins which include patient self reports and self assessment
Woolett & Clegg, 1989	longitudinal; structured interviews at 30 weeks gestation, and at 3-4 days postbirth, 8 areas where women asked to respond: reproductive history; diagnosis of twin pregnancy; problems in pregnancy, medical events around birth; other events around birth; womens' ratings of pregnancy and birth; size and state of infants (no other information about approach specified)	n=40 women	investigate three issues: general patterns of womens' experiences and reactions to twin pregnancy; factors associated with womens' reactions, especially parity and reproductive problems; the implication for theories of the development of attachment	results highlight percentages of responses (ie. 67.5% experienced nausea); discusses womens' reports of the pregnancy and birth
Rydhstrom, 1990	retrospective review of national birth registry data; epidemiologic	n=22,374 twin births in Sweden between 1973 and 1985; n=972 died perinatally	to evaluate the effect of maternal age, parity, and sex on twin perinatal mortality	significantly greater perinatal mortality for: like sexed twins, male pairs, monozygotic twins, women having first delivery; no association with maternal age

Quantitative Methods: Pre and Post birth Periods				
Citation	**Measure**	**Sample**	**Purpose**	**Findings**
Thorpe, Greenwood, & Goodenough, 1995	physical well being measured by self report (general subjective rating and specific symptoms); emotional well being measured with Edinburgh Postnatal Depression Scale (no further information given about measures) compares two groups	n=147 women pregnant with twins; n=11,061 women expecting a singleton	to compare the impact of a twin pregnancy with that of a single pregnancy on a woman=s physical and emotional well-being	subjective experience of physical health is more negative for women expecting twins, particularly in early and mid pregnancy; women expecting twins do not have poorer emotional well being in pregnancy; poor physical health was associated with poor emotional well being for all women in the study. No recommendations for further research.
Olivennes et al., 1996	retrospective analysis of chart data; compares groups on outcome measures high blood pressure, prom, prematurity, sga, c-section, perinatal mortality (conducted in France)	n=72 women who conceived after IVF-ET; n=82 women who conceived after ovarian stimulation; n=164 women who conceived spontaneously	to compare the perinatal outcome of IVF-ET twin pregnancies to twin pregnancies conceived spontaneously or after ovarian stimulation without IVF-ET	the risk of adverse perinatal outcome is not increased when compare with spontaneous pregnancies or those after ovarian stimulation; women of the IVF-ET group were older and of higher SES.
Augustsson, Geirsson, & Mires, 1997	compares two groups via survey (conducted in Scotland and Iceland)	n=522 (n=453 natural conceptions; n=69 assisted conceptions	to evaluate how assisted conception influences obstetric management and outcome in twin pregnancy	elective c-section used more often in assisted conceptions; no difference in induction rates; no differences in mode of delivery once labor commenced, no differences in neonatal short term morbidity; no differences in birthweight, gestational length, or perinatal mortality in the two groups